## J1 SUMMER WORK TRAVEL PROGRAM

**Health Screening (To be completed by participant)**

ACES
A CULTURAL EXCHANGE SERVICE

_____ _____ _____

Last Name First Name Date of Birth (MM/DD/YYYY)

**Gender:** Male Female **Height:** _____ (in feet and inches) **Weight:** _____ (in pounds)

**General Health Questions:** If you answer "Yes" to any of these general health questions please give full details on a separate sheet of paper.

| | | | | | |
|---|---|---|---|---|---|
| Is your physical activity restricted in any way? | Yes | No | Do you have any dietary restrictions? | Yes | No |
| Do you have a chronic or recurring illness? | Yes | No | Are you currently taking any medications? | Yes | No |
| Have you ever been treated by a psychiatrist? | Yes | No | Have you ever undergone surgery? | Yes | No |
| Have you ever received treatment for a nervous or emotional issue? | Yes | No | | | |

**Health History** (Check all that apply)

| | | | |
|---|---|---|---|
| Anemia | Dizziness/Fainting | Heart Disease | Mumps |
| Anorexia | Ear Infection | Hepatitis A/B/C | Pregnancy |
| Arthritis | Epilepsy/ Seizures | Kidney Disease | Rheumatic Fever |
| Asthma | Eye Problems | Malaria | Scarlet Fever |
| Bulimia | Gallbladder Problems | Measles | Tuberculosis |
| Chicken Pox | German Measles | Menstrual Problems | Ulcers |
| Depression | Glandular Fever | Migraine/ Headaches | Venereal Disease |
| Diabetes | Other | | |

If you check any of the above, please give details (including dates) on a separate sheet of paper.

**Abnormalities of Organs or Systems** (Check all that apply)

| | | | |
|---|---|---|---|
| Cardiovascular | Head, ears nose, throat | Reproductive | Metabolic |
| Respiratory | Eyes (including glasses or contacts) | Gastrointestinal | Skin |
| Genitourinary | Musculoskeletal | Nervous | Other |

If you check any of the above, please give details (including dates) on a separate sheet of paper.

**Allergies** (Check all that apply)

| Allergies | Describe reaction: | Management or treatment: |
|---|---|---|
| Hay Fever | | |
| Insect Sting | | |
| Penicillin | | |
| Other drugs | | |
| Other: | | |

**Insurance Information:**

If you are a US citizen, F1 OR a J1 participant covered by a **different** insurance than that provided by your sponsor, please give details:

Carrier Name: _____ Contact Phone Number: _____

Carrier/Plan Number: _____ Group or Policy Number: _____

**Emergency Contact** **Must speak English**

Name: _____ Relationship to Applicant: _____

Email: _____ Telephone: _____

**I certify that all information given is true to the best of my knowledge, and I hereby give permission for emergency medical care should it be necessary.**

_____ _____

**Signature** **Date (MM/DD/YYYY)**

## J1 SUMMER WORK TRAVEL PROGRAM

**Health Screening (To be completed by physician)**

ACES
A CULTURAL EXCHANGE SERVICE

| Last Name | First Name | Date of Birth (MM/DD/YYYY) |
|---|---|---|
| _____ | _____ | _____ |

As an exchange visitor participant, the above named student will be traveling abroad with the intention of interacting with and potentially living with American citizens as an ambassador of his/her home country. As part of the program, the participant is permitted to and/or expected to work to offset travel and program costs. It is therefore important that we are advised of any physical or mental health problems that may have a bearing on the applicant's ability to accept such responsibilities.

Please review the information provided by the applicant on Page 1 of this form and answer the following questions. (Circle One)

***The above named applicant is in good physical condition.*** **Correct** **Incorrect**

***The above named applicant does NOT have any physical issues that might negatively affect or hinder his/her ability to work.*** **Correct** **Incorrect**

***The above named applicant does NOT have any emotional issues that might negatively affect or hinder his/her ability to work or to socially interact and/or reside with American citizens.*** **Correct** **Incorrect**

**Other Comments:**

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Please provide the date for each immunization (Those in bold are required for some camp employment):

**COVID 19 Vaccination: Date Dose 1 _____ Product _____ Date Dose 2 _____ Product _____**

| | | | |
|---|---|---|---|
| **Measles**<br>Date | **Mumps**<br>Date | **Rubella (German Measles)**<br>Date | **Meningococcal Meningitis - MCV4**<br>Date |
| **Diphtheria**<br>Date | **Tetanus**<br>Date | **Pertussis**<br>Date | **Varicella (Chicken Pox)**<br>Date |
| **Hepatitis B**<br>Date | Hepatitis A<br>Date | Polio – IPV<br>Date | HIB Haemophilus Influenzae Type B<br>Date |
| Rotavirus<br>Date | Pneumococcal Conjugate – PVC 13<br>Date | Tdap – 10 year Booster<br>Date | Whooping Cough<br>Date |
| TB Mantoux test<br>Date | H1N1 – Swine Flu<br>Date | Most current Flu Shot<br>Date | Typhoid<br>Date |

_____ _____
Signature of Licensed Medical Personnel Date (MM/DD/YYYY)

_____ _____
Printed Name of Licensed Medical Personnel Title

_____ _____
Telephone Email