Connecting Lives, Sharing Cultures

Health Certificate (Page 2 of 2)

CANDIDATE NAME MS./MISTER_____	HOME COUNTRY **THAILAND**

14. Are there any health limitations or restrictions on the candidate's activities and /or sports participation or any medical information which should be considered for a home/ school placement? ☐ No ☐ Yes

If yes, please describe:

15. Does the candidate wear glasses or contact lenses? ☐ No ☐ Yes

16. What was the date of the candidate's last dental checkup? Date: _____/_____/_____

Does the candidate wear dental braces? ☐ No ☐ Yes

If yes, will orthodontic care be needed while on the program? ☐ No ☐ Yes | FREQUENCY

17. Please specify exact day, month and year that the candidate had the following **immunizations:**

☐ **Tuberculosis (BCG)**
DOSE 1
Date: ___/____/____

☐ **Measles /Mumps/Rubella : MMR vaccinations**
DOSE 1 Date: ___/____/____
DOSE 2 Date: ___/____/____
☐ Booster Dose Date: ___/____/____

☐ **Diphtheria, Pertussis and Tetanus : DPT vaccinations**
DOSE 1 Date: ___/____/____
DOSE 2 Date: ___/____/____
DOSE 3 Date: ___/____/____
DOSE 4 Date: ___/____/____
DOSE 5 Date: ___/____/____
☐ **Booster Dose (circle one)** *DPT, DTaP , Td, Tdap , DTap Other*_____
1) ___/____/___ 2) ___/___/___ 3) ___/____/____

☐ **Poliomyelitis : (OPV/IPV)**
DOSE 1 Date: ___/____/____
DOSE 2 Date: ___/____/____
DOSE 3 Date: ___/____/____
DOSE 4 Date: ___/____/____
☐ Booster Dose Date: ___/____/____

Chicken pox Disease History :
☐ Yes ☐ No If **Yes,** When ? Month_____ Year _____

☐ **Varicella**
DOSE 1 Date: ___/____/____
DOSE 2 Date: ___/____/____

☐ **Meningococcal**
Date: ___/____/____

☐ **Hepatitis B (HBV)**
DOSE 1 Date: ___/____/____
DOSE 2 Date: ___/____/____
DOSE 3 Date: ___/____/____
☐ Booster Dose
Date: ___/____/____ Date: ___/____/____ Date: ___/____/____

☐ **Hepatitis A (HAV)**
DOSE 1 Date: ___/____/____
DOSE 2 Date: ___/____/____

☐ **Combination Hepatitis A and B**
Date: ___/____/____ Date: ___/____/____ Date: ___/____/____

☐ **Other vaccinations:** (for example, JE or Japanese Encephalitis vaccine)
Vaccine_____ Date: ___/____/____
Vaccine_____ Date: ___/____/____
Vaccine_____ Date: ___/____/____
Vaccine_____ Date: ___/____/____
Vaccine_____ Date: ___/____/____

Can the student receive immunizations? ☐ Yes ☐ No If no, please explain :

☐ Hepatitis B antigen, antibody, blood test to be undertaken and results attached for:
HBsAg→☐ Positive ☐ Negative **HBsAb→** ☐ Positive ☐ Negative **Hepatitis B carrier** ☐ No ☐ Yes
Doctor's comment _____

TB Test--which type ☐ Mantoux ☐ Tine Date: ____ / ____ /____	Result ☐ + ☐ - _____ mm (Skin test result size)
If positive, was chest x-ray done? ☐ No ☐ Yes Date: ____ / ____ /____	Result ☐ Abnormal ☐ Normal
Optional : IGRA Blood Test Date: ____ / ____ /____	Result ☐ Negative ☐ Positive ☐ Indeterminate
If positive or indeterminate, was chest x-ray done? ☐ No ☐ Yes Date: __ / __ /___	Result ☐ Abnormal ☐ Normal

I, the undersigned, certify that a thorough physical examination of the candidate has been given and all important recent medical information has been included on the health certificate, that nothing relevant has been omitted, and that the candidate is able to travel. I understand that the omission of any information could be harmful to the candidate's health care and could result in early termination from the AFS program.

PHYSICIAN NAME AND DEGREE	SIGNATURE
ADDRESS	DATE: ___/____/____

Your signature below attests that you understand and accept the AFS Medical Policies as stated on the Participation Agreement, that the information on the health certificate is correct and complete and that inaccurate or incomplete information could be harmful to the candidate's health care and could result in early termination from the AFS program.

CANDIDATE SIGNATURE	DATE: ___/____/____
PARENT / GUARDIAN SIGNATURE	DATE: ___/____/____