



# PARTNERS *of the* AMERICAS

Oregon - Costa Rica  
High School Exchange Program

## HEALTH CERTIFICATE

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

**To the physician:** The student presenting this health certificate will be traveling with a student exchange program which includes: air travel from Oregon to Costa Rica and return; living with two different families (one month with each); possibly traveling throughout the country of Costa Rica; attending two different high schools; eating many different kinds of food; enduring minor physical discomforts; adapting to different customs and culture; and being exposed to perhaps a greater emotional and physical stress than at home.

We appreciate your cooperation in sending us the requested confidential information in order that the applicant is not subjected to a situation to which he/she cannot adapt, or which may be detrimental to his/her health. It is also necessary for the Oregon Partners of the Americas and the Chaperones to have sufficient information pertaining to the participant's health in case of an emergency in Costa Rica.

PLEASE INDICATE:	YES	NO	UNCERTAIN	PLEASE INDICATE:	YES	NO	UNCERTAIN
Allergy				Behavior difficulty			
Seizures				Serious accident			
Diabetes				Exposure to TB			
Fainting spells				Other illnesses			
Heart trouble				Other operations			
Any medication							

If YES or UNCERTAIN marked for any of the above, please explain fully here (list medications in "PRESCRIPTIONS" space): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESCRIPTIONS** (Please list any, and **provide applicant with a valid written prescription** using generic name of drug. This will be taken to Costa Rica in case of emergency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIMITATIONS OR CONDITIONS:** pertaining to the activities of this student, necessary for safeguarding his/her health, are as follows:

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**REMEDIAL MEASURES:** before travel, or periodic checkups abroad, have been recommended to the applicant as follows:

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**PERSONALITY AND BEHAVIOR** (Describe):

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**IMMUNIZATION RECORDS:** Please provide a record of standard immunizations, including names and dates of immunizations, for the student. (A photocopy of immunization records is helpful for our chaperones in Costa Rica).

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### **CERTIFICATE**

I have examined the above-named applicant on (date) \_\_\_\_\_, and, except as noted above, have found him/her free of any communicable disease and to be physically fit for the experience described.

\_\_\_\_\_  
Print name of physician

\_\_\_\_\_  
Signature of physician

**ADDRESS OF PHYSICIAN:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

### **INSURANCE INFORMATION**

**Name of Medical Insurance Carrier/Administrator:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_

Telephone # inside U.S.: \_\_\_\_\_

Telephone # outside U.S.: \_\_\_\_\_