PART ONE

PHYSICIAN'S STATEMENT OF HEALTH

Rodriguez Castro
STUDENT'S FAMILY NAME (AS IT APPEARS ON PASSPORT, ID CARD OR BIRTH CERTIFICATE)

Luis
FIRST NAME

Antonio
MIDDLE NAME

Please complete this form in **BLACK** ink.

Does the candidate have or has the candidate ever had any of the following illnesses or symptoms?

If yes, please mark relevant circles and provide a clear, legible explanation in the space below. (Use additional sheet if needed)

- ◯ Angina
- ◯ Appendicitis
- ◯ Asthma
- ◯ Contact Dermatitis
- ◯ Epilepsy
- ◯ Diabetes
- ◯ Drugs sensitivity (eg penicillin…)
- ◯ Eating disorder (anorexia, bulimia, other:)
- ◯ Enuresis
- ◯ Febrile Seizures
- ◯ Hernia
- ◯ Hepatitis (if yes, which one:)
- ◯ Learning or speech defect
- ◯ Malaria
- ◯ Meningitis
- ◯ Migraine (with aura, nausea and vomiting)
- ◯ Parasites
- ◯ Rheumatic Fever (Acute)
- ◯ Scarlet Fever
- ◯ Sleepwalking
- ◯ Urticaria
- ◯ Vertigo, dizziness
- ◯ Other (please list) NO

Explanation (date of illness, treatment, is issue ongoing, …)

NO

Will the student be using drugs or medication while abroad?

⊗ No ◯ Yes (please explain, use additional sheet if needed)

Has student ever been hospitalised?

⊗ No ◯ Yes (please explain, use additional sheet if needed)

Has student ever consulted a medical specialist?

⊗ No ◯ Yes (please explain, use additional sheet if needed)

Obligatoriamente:
Firma y Sello del Doctor

I, the undersigned, h
history of the above named candidate. I certify that all important medical information has been included, and that the above information is complete and accurate. I certify that the above named student is emotionally and physically fit to engage in a secondary school program abroad.

Dr. Jaime Segura Teller

PHYSICIAN: NAME
Medical Practitioner must not be a direct family member

SIGNATURE

DATE 13/10/22.

Does the candidate have or has the candidate ever had any impairment to the following?

If yes, please mark relevant circles and provide a clear, legible explanation in the space below. (Use additional sheet if needed)

- ◯ Brain, nervous system
- ◯ Bones, joints, locomotor system
- ◯ Ears or hearing
- ◯ Endocrine system
- ◯ Esophagus, stomach, intestines, liver
- ◯ Eyes or vision
- ◯ Heart, blood, vessels (high blood pressure…)
- ◯ Hematopoietic system, spleen
- ◯ Kidneys, genito-urinary system
- ◯ Lungs, respiratory system
- ◯ Nose, throat (tonsils…)
- ◯ Skin (acne)
- ◯ Other (please list) NO

Explanation (date of illness, treatment, is issue ongoing, …)

NO

Has the candidate ever consulted with or been treated by a specialist for any of the following?

If yes, please mark the appropriate circles and provide a clear and legible explanation in the space below. (Use additional sheet if necessary)

- Alcoholism ◯
- Attempted suicide ◯
- Behavioural problems ◯
- Eating Disorder (anorexia, bulimia etc) ◯
- Psychological/Emotional illness ◯
- Self-injury ◯
- Substance abuse ◯

Explanation (if 'YES' to any of the above)

NO.

PHYSICIAN'S STAMP HERE

PART TWO

PHYSICIAN'S STATEMENT OF HEALTH

Rodriguez Castro
STUDENT'S FAMILY NAME (AS IT APPEARS ON PASSPORT, ID CARD OR BIRTH CERTIFICATE)

Luis
FIRST NAME

Antonio.
MIDDLE NAME

Please complete this form in **BLACK** ink.

Please provide information for the following:

HEIGHT	1.75 m x 39.37 = 68.89 inches ÷ 12 = 5.74 feet inches 1 metre (m) = 39.37 inches (") = 3.28 feet (')
WEIGHT	73.5 kg x 2.2 = 161.7 lbs ÷ 14 = 11.55 st lbs 1 kilogram (kg) = 2.2 pounds (lb) = 0.157 stone
BLOOD PRESSURE	104/43 (67) mHg
BLOOD GROUP If known	A Rh Factor Rh (positive) +
URINE	Sediment Glucose (0, +, ++, +++) Proteins (0, +, ++, +++)

VISION With correction if necessary

	Right Eye (OD)			Left Eye (OS)		
If the student wears ◯ glasses or ◯ contact lenses, please complete the following Ophthalmic information:						
	Right Eye			**Left Eye**		
	Spherical	Cylindrical	Axis	Spherical	Cylindrical	Axis
Distant Vision (DV)						
Near Vision (NV)						

Are pupillary and knee reflexes normal?	☒ Yes	◯ No (please explain, use additional sheet if needed)
Does the student have any scars or identifying marks?	◯ Yes (please explain, use additional sheet if needed)	☒ No
Are there any restrictions on the student's participation in sports activities or physical education?	◯ Yes (please explain, use additional sheet if needed)	☒ No

Describe in detail each disease, impairment or abnormality not fully explained in these forms (Parts One and Two) on a separate sheet of paper (signed and stamped).

Please give your opinion of the candidate's health:
☒ Excellent ◯ Good ◯ Fair ◯ Poor

Obligatoriamente:
Firma y Sello del Doctor

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the above named candidate. I certify that all important medical information has been included, and that the above information is complete and accurate. I certify that the above named student is emotionally and physically fit to engage in a secondary school program abroad.

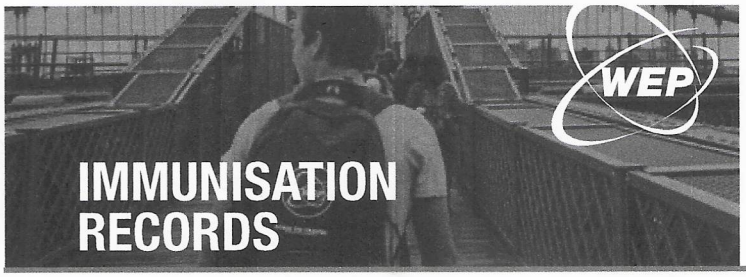
Dr. Jaime Segura

PHYSICIAN: NAME
Medical Practitioner must not be a direct family member

SIGNATURE

DATE 13/10/23

PHYSICIAN'S STAMP HERE



IMMUNISATION RECORDS

Rodriguez Castro
STUDENT'S FAMILY NAME (AS IT APPEARS ON PASSPORT, ID CARD OR BIRTH CERTIFICATE)

Luis
FIRST NAME

Antonio
MIDDLE NAME

Please complete this form in **BLACK** ink.

To be completed by the attending physician. Vaccination requirements may vary from one country to another. Unless otherwise instructed, please provide all dates requested. This cill determine the student's acceptance into the host country school. Due to change in distrcit or school regulations in the host country, participants may be required to provide additional immunisations before departure or after arrival. Please provide information for the following:

23 / 10 / 2006
STUDENT'S DATE OF BIRTH (dd/mm/yy)

Vaccination requirements do change from time to time.
WEP will advise if students are obliged to have additional vaccinations.

Vaccines Enter dates as: dd/mm/yy	DATE OF 1st dose given	DATE OF 2nd dose given	DATE OF 3rd dose given	DATE OF 4th dose given	DATE OF 5th dose given	DATE OF 6th dose given
DTaP or DTP [1]	29/10/2006	29/11/2006	01/04/2007	28/10/2007	29/11/2007	29/11/2010
Tdap [2]	/ /					
Polio [3]	/ /	/ /	/ /	/ /	/ /	
Measles [4]	/ /	/ /	• If NO immunisation, give date student had Measles: / /			
Mumps [4]	/ /	/ /	• If NO immunisation, give date student had Mumps: / /			
Rubella [4]	/ /	/ /	• If NO immunisation, give date student had Rubella: / /			
Varicella [5] Required if student has not had Chickenpox	/ /	/ /	• If NO immunisation, give date student had Chickenpox: / /			
Hepatitis A [6] (USA only)	/ /	/ /				
Hepatitis B [7]	/ /	/ /	/ /			
Tuberculin Skin Test (Mantoux) [8] If applying to the USA, please complete the additional TB test form in the DOCUMENT section. *OR*	☐ + Positive ☐ - Negative Date of TB Mantoux Test: / / • If TB Skin Test positive, report of negative chest X-ray required. (See below)					
TB Blood Test (IGRA/QuantiFERON TB-Gold) [8]	/ /	☐ IGRA/QuantiFERON TB-Gold Result: ☐ + Positive ☐ - Negative				
Chest X-Ray Chest X-ray only required if tuberculosis test is positive.	/ / Result: ☐ + Positive ☐ - Negative					
Meningococcal Vaccine [9] (USA only)	/ / ☐ Meningococcal C		/ / / / ☐ MCV4 ☐ Other (specify)			
Yellow Fever [10] (Brazil and Argentina only)	Date of Yellow Fever vaccination: / /					
Covid-19	20/06/2020	18/09/2021	/ /	Name of the vaccine: Pfizer.		

1. **Diphtheria, Tetanus and Pertussis (DTaP or DTP)**: 4 or more are required. One dose must be received after the student's 4th birthday.
2. **Tetanus, Diphtheria** and **Pertussis Booster (Tdap)**: Tdap must have been administered within 10 years of the end date of the WEP program or, for the USA, received within the last 5 years. EU students may substitute Tdap with dTap.
3. **Polio**: 3 or more (4 for the USA). One dose must be received after the student's 4th birthday.
4. **Measles, Mumps** and **Rubella**: 2 doses required.
5. **Varicella**: One dose, except Argentina and USA where two doses are required.
6. **Hepatitis A**: For the USA only, two doses are required, after the age of two, at least six months apart.
7. **Hepatitis B**: Countries, except USA, accept either a two dose or three dose schedule. For the USA, students must have received three doses of Hep B vaccine. (See Applications to the USA) NOT REQUIRED for applicants to European countries.
8. **TB skin test (TST)** or **Interferon Gama Release Assay blood test (IGRA/QuantiFERON TB-Gold)** must have been administered within 12 months prior to departure. Required for Argentina, Canada, Italy and USA. If the student chooses the TST, a signed, dated copy of the test results is required for the USA.
9. **Meningococcal**: For the USA only. MenCCV2 – one (1) dose at 12 months is required, PLUS (if possible) MCV4 – two (2) doses are required with the 1st dose given between 13–15 years and the second given between 16–18 years. If the first dose is given after the 16th birthday, a booster is not needed.
10. **Yellow Fever Vaccination** required for students entering Brazil, students entering the Misiones province of Argentina, Brazilian students entering Australia and Argentine students from the Misiones province of Argentina entering Australia. Yellow Fever vaccination is recommended for all students to Argentina.

Comments

Obligatoriamente:
Frima y Sello del Doctor.

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the above named candidate. I certify that all important medical information has been included, and that the above information is complete and accurate. I certify that the above named student is emotionally and physically fit to engage in a secondary school program abroad.

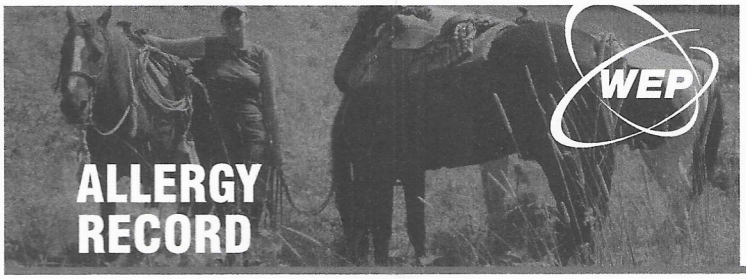
Dr. Jaime Reyes

PHYSICIAN NAME
Medical Practitioner must not be a direct family member

SIGNATURE

13/10/23
DATE

PHYSICIAN'S STAMP HERE



ALLERGY RECORD

Rodriguez Castro
STUDENT'S FAMILY NAME (AS IT APPEARS ON PASSPORT, ID CARD OR BIRTH CERTIFICATE)

Luis
FIRST NAME

Antonio
MIDDLE NAME

Please complete this form in **BLACK** ink.

Some exchange organisations do not accept students with allergies. If there are any significant changes to the information entered on this form before your departure or during your program, we reserve the right to cancel your program. Since the host family location is not known in advance, all allergies (controlled by medication or not, environmental, seasonal etc) must be declared. False declarations may result in immediate dismissal from the program without refund.

Can any of the allergic reactions, listed below, be life threatening? ◯ Yes ⊗ No

If **YES** please explain

Can the symptoms be controlled with medication? ◯ Yes ⊗ No

If **YES**, please provide information (list of medications and schedule of use)

Allergies to Living Conditions

(please tick the appropriate box)

Does the student have any allergic reactions to the following?

◯ Dust ◯ Mould ◯ Pollen ◯ Grass
◯ Medications ◯ Insect venom ◯ Cigarette smoke
◯ Other (please specify) NO

Please describe the student's symptoms:

Allergies to Animals *(please tick the appropriate box)*

Does the student have any allergic reactions to the following?

◯ Cats ◯ Dogs ◯ Horses
◯ Rabbits ◯ Birds
◯ Other (please specify) NO.

What breeds of dogs/cats or other animals is the student allergic to?

Please describe the student's symptoms:

Can the student live in a home with a dog that lives outdoors? ⊗ Yes ◯ No
Can the student live in a home with a dog that lives indoors? ⊗ Yes ◯ No
Can the student live in a home with a cat that lives outdoors? ⊗ Yes ◯ No
Can the student live in a home with a cat that lives indoors? ⊗ Yes ◯ No

Can the student live in a home with animals, if the animal is not permitted in the student's bedroom? ⊗ Yes ◯ No

Food Intolerances and Other Allergies

Please list: NO

Please describe the student's symptoms:

Can the student prepare own meals to accommodate allergy/intolerance? ◯ Yes ◯ No

Obligatoriamente:
Firma y Sello del Doctor

I, the undersigned, certify that all available information regarding the student's allergies has been included, and that the above information is complete and accurate.

PHYSICIAN: NAME Dr. Jaime Seura

SIGNATURE

DATE 18/10/23

Physician must not be a direct family member.

PHYSICIAN'S STAMP HERE