



Mutual Friends Student Exchange, Inc

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Medical Examination Form & Immunization Record

STUDENT NAME:		BIRTH DATE:	
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INSTRUCTIONS: Print this document and have it filled out by your family physician or medical doctor **OR** email to doctor for electronic form input. Then, return to MFSE by email: vs@mfse.biz or fax to: 717-431-8879.

PHYSICAL EXAMINATION OF THE STUDENT

Height:		Vision:	R		/		L		/	
Weight:		With Correction:	R		/		L		/	<input type="checkbox"/> N/A
Pulse:		Hearing:	R		/		L		/	
Blood Pr.:		With Correction:	R		/		L		/	<input type="checkbox"/> N/A
Urinalysis:	S.B.	ALB.	Sugar		Micro					

Physical examination of body

Explanation of abnormal findings

Appearance	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Eyes/ears/nose & throat	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lymph nodes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Cardiovascular	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Cardiopulmonary	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Genitourinary	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Neurological	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Musculoskeletal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Tuberculosis Tests

Skin test:	Date:		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative – Follow-up:	
Mantoux test:	Date:		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative – Follow-up:	
Chest x-ray:	Date:		<input type="checkbox"/> Radiological findings attached		

Other Information

Date of last dental examination:		<input type="checkbox"/> Dental Examination Form attached
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Any current orthodontic care?	
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Immunization Record

STUDENT NAME:					BIRTH DATE:			
Vaccine:		Date each dose was given						
		1	2	3	4	5		
Diphtheria/Tetanus/Pertussis (DPT and/or DT)								
Polio (OPV or IVP)								
Hepatitis B								
Measles (vaccine/disease)	OR MMR				Date student had disease			
Mumps (vaccine/disease)					Date student had disease			
Rubella (vaccine/disease)					Date student had disease			
Varicella (Chicken Pox) (vaccine/disease)					Date student had disease			
Meningococcal (MVC)								

Vaccination Requirements

Diphtheria/Tetanus/Pertussis (DPT) Or Diphtheria/Tetanus (TD) only 7 years or older	At least 4 doses At least 3 doses	Additional doses required if the last dose was received before age 2 years
Polio	At least 3 doses	
Hepatitis B	At least 3 doses	
Measles/Mumps/Rubella (MMR)	MMR 2 doses after age 15 months	
Varicella	At least 1 dose	

DOCTOR'S SIGNATURE

I, the undersigned physician, certify that I have performed a comprehensive physical examination and reviewed the health history of this student. I certify that all important medical information has been included and that this information is complete and accurate.

Signature of Physician		Date	
Physician's printed name		Telephone number (including country code)	
Address of clinic		Seal or Stamp	