

## **MEDICAL REFERENCE**

To be completed by the student's doctor. Student's signature also required.

**STUDENT'S NAME:** \_\_\_\_\_

Does the student take medications (prescription or non-prescription) on a regular basis?

Yes  No If Yes, please describe.

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

Does the student use tobacco or e-cigarette (vaping) products?  Yes  No

Please reply honestly or risk removal from the Homestay Program. Many host families will refuse a student who uses tobacco or vape products, even experimentally. **Sale of tobacco related products is ILLEGAL for minors.**

Does the student have any condition, either documented or perceived, including a medical condition, learning disability, special need, behavior disorder, physical disability, addiction, or mental disorder that may affect his/her ability to successfully participate and succeed in the International Education Program, or that may require treatment and/or special support at school or from a homestay family?

Yes  No If yes, please describe. Further information may be requested.

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

*Possessing a condition or disability will not necessarily make the student inadmissible. However, the School District must be able to accommodate the student's condition without additional costs. Failure to disclose pertinent information could lead to dismissal.*

I certify that the above information to be true and correct.

\_\_\_\_\_  
Student Name Student Signature Date

**DOCTOR'S CONFIRMATION:** I have reviewed the above student's medical history and can confirm, to the best of my knowledge, the student's suitability for studying abroad in a foreign country based on his/her medical history is as follows:  Excellent  Good  Fair  Poor  Unsuitable

Doctor's Name: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Stamp of Doctor, Clinic, or Hospital*

*Here (Absolutely Required!)*

**Thank you for completing the form. We appreciate your time.**