
Rotary Youth Exchange Long-Term Program Application

NAYEN(North American Youth Exchange Network)2022.5.12
RIJYEM 2023.07Ver.



RIJYEM
RI JAPAN YOUTH EXCHANGE MULTI DISTRICT



Submit completed application to:

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Number of Copies of Application to be Submitted: _____



Rotary Youth Exchange – Long-Term Exchange Program

Section C-1: Medical History & Examination

Physician: This student is considering a year abroad as an exchange student. Insufficient, inadequate, or improper information about medications or psychiatric, psychological, or other medical problems could endanger the student’s life while overseas. Allergy information is especially crucial to host family placement and student well-being. An immediate relative of the applicant may **not** complete the examination or fill out this form.

Use computer entry if possible. Consult Rotary Sponsor District Instructions for required copies and signatures. Print specified number of completed copies first for ink signatures on paper (if required). Electronic signature(s) may be applied last if both paper and electronic signatures are needed.

Full Legal Name as on passport or birth certificate (use uppercase for FAMILY name; e.g. John David SMITH)		Date of Birth (YYYY-MM-DD)		Male Female Non-Binary
Home Address – Street		City	State/Province	Postal Code
E-mail Address		Home Phone Number		Mobile Phone Number
				Country

Medical History

1. How long has the applicant been the patient of the physician?		
2. Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for:		
a. Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Anorexia/bulimia/other eating disorder*	<input type="checkbox"/>	<input type="checkbox"/>
c. Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
f. Attention deficit disorder*	<input type="checkbox"/>	<input type="checkbox"/>
g. Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>
h. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
i. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
j. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
k. Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
l. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
m. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
n. Liver disease/hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
o. Malaria	<input type="checkbox"/>	<input type="checkbox"/>
p. Menstrual disorders	<input type="checkbox"/>	<input type="checkbox"/>
q. Mental disorders*	<input type="checkbox"/>	<input type="checkbox"/>
r. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
s. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
t. Serious headache/migraine	<input type="checkbox"/>	<input type="checkbox"/>
u. Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>
v. Typhoid fever	<input type="checkbox"/>	<input type="checkbox"/>
w. Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>
x. Vertigo/dizziness	<input type="checkbox"/>	<input type="checkbox"/>
y. Visual correction – eyeglasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
z. Visual problems – other	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the applicant:		Yes No
a. Had any surgical operation not revealed in question 2, or gone to a hospital, clinic, dispensary, or sanatorium for observation, examination, or treatment not revealed in question 2?		<input type="checkbox"/> <input type="checkbox"/>
b. Taken any prescribed medication in the past six months?		<input type="checkbox"/> <input type="checkbox"/>
c. *Presented any history or current evidence of nervous, emotional, or mental abnormality, functional nervous breakdown, nervous fatigue, depression, suicide attempts, eating disorders, or antisocial behavior?		<input type="checkbox"/> <input type="checkbox"/>
d. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs?		<input type="checkbox"/> <input type="checkbox"/>
e. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician/other practitioner or an organization that assists those who have an alcohol or drug problem?		<input type="checkbox"/> <input type="checkbox"/>
f. Had excessive weight gain or loss recently?		<input type="checkbox"/> <input type="checkbox"/>
g. Suffered chest pain, wheezing, shortness of breath, or fainting episodes?		<input type="checkbox"/> <input type="checkbox"/>
h. Suffered chronic diarrhea, vomiting, abdominal pain, or constipation?		<input type="checkbox"/> <input type="checkbox"/>
i. Exhibited chronic skin conditions (e.g., severe acne, eczema, psoriasis)?		<input type="checkbox"/> <input type="checkbox"/>
j. Suffered weakness of neurological or muscular skeletal system?		<input type="checkbox"/> <input type="checkbox"/>
k. Had any dietary restrictions? If yes, specify and note reason (medical, religious, personal choice):		<input type="checkbox"/> <input type="checkbox"/>
If you answered "Yes" for any parts of questions 2 and 3, please explain (except non-medical dietary restrictions): *Affirmative answers to questions 2b, 2f, 2q, and/or 3c require a letter of explanation from the treating physician		
Question (e.g., 2e)	Nature and severity of disorder, diagnosis, frequency of attacks, prognosis, and treatment	Dates and duration



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Section C-1: Medical History & Examination

7. Will the applicant be bringing any prescribed medication on the exchange? Yes No
 If yes, please list each medication, including the international and generic names, compound symbols, dosage, frequency and reason for use:

Prescribed Medication	Dose/Frequency	Reason for Use

Physical Examination

Examination Date:	Height: (cm)	Weight: (kg)	Blood Pressure: Systolic (mmHg)	Diastolic	Pulse: (rate/minute)
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8. Does today's examination show any abnormal findings for:

Yes		No		Yes		No		Yes		No	
Head and neck				Heart (murmur, rhythm)				Extremities (muscles)			
Ear, nose, throat				Hernias				Skeletal system			
Chest/lungs				Lymph nodes/breasts				Neurological			
				Genitalia (external)							
											Abdomen (mass)
											Skin
											Rectal
											Not done (See below)

Rectal exam is not required if bowel history and abdominal exam are normal. For any "YES" (abnormal) in part 8, above, please provide detailed information on a separate page (typed or computer-generated with the applicant's full legal name and date of birth at the top of each page).

CERTIFICATION

I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient, and that I have personally examined the applicant and reported my findings as noted above and the attached page(s) (if additional pages are attached, please check here).

I find the applicant:

- In good health and not suffering from any mental or medical condition(s) that would preclude participation in the Rotary Youth Exchange program.
- Suffering from mental or medical condition(s) as noted in my report that could impact his/her participation.

Additionally, I find the applicant in good health and not suffering from any condition(s) that would preclude participation in sporting/physical activities of the applicant's choice Yes No

Physician address, phone, fax and E-mail	Physician Name
	Physician Signature (ink on paper) or basic e-signature (using Fill & Sign); click only for digital signature
	Date (YYYY-MM-DD)

Parent and Applicant Declaration:

We/I hereby confirm:

- (1) that the Medical Sections C-1 and C-2 with Dental Section D include ALL the health information known to us/me. Incomplete Medical or Dental Sections may lead to an early termination of the exchange.
- (2) that the exchange student will be fully vaccinated according to the requirements of the receiving host country, host Rotary district or school.
- (3) that if additional medical issues arise between the completion of this application form and the exchange departure date, sponsor and host districts will be notified immediately.
- (4) I further authorize the Rotary Youth Exchange Officer, the Rotarian Counselor and/or the host parents to serve as my child's/my representative for the purpose of receiving medical information and communicating with medical providers about my child's/my medical condition.

Parent/Legal Guardian #1 Signature: Name: Date:	Applicant Signature: Name: Date:
Parent/Legal Guardian #2 Signature: Name: Date:	This form provides for authenticated digital signatures by clicking on signature fields. Basic electronic signatures are applied instead using Fill & Sign Tool without clicking on signature field. Leave signature fields empty to print and apply ink signature for scanned copies. Doing all signatures the same way is usually best, but ink and basic electronic signatures can be mixed. Follow RYE Sponsor District instructions regarding suitable signatures for this application.

Letter(s) of explanation from treating physician(s), if any, and separate pages for any abnormal physical findings are to be appended following this page.

Applicant Name 申請者氏名: _____	
Date of Birth 生年月日: _____	AGE 年齢: _____ Sex 性別 <input type="checkbox"/> male 男 <input type="checkbox"/> female 女

Indicate year when the applicant had the following infectious diseases (or indicate that he or she has not) / 感染性疾患の罹患履歴(年)			
Measles(rubeola)はしか <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____	Mumps おたふく風邪 <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____	Hepatitis 肝炎(if so, see comments) (コメントに詳細記入) <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____	Whooping cough(pertussis)百日咳 <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____
Rubella(German measles) 風しん <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____	Varicella (Chicken Pox) 水疱瘡 <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____	Scarlet fever 猩紅熱 <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____	Other(その他): Covid-19 <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____

Dates of immunizations (clearly state the dates of ALL doses received in ISO format- YYYY-MM-DD) Immunizations are a prerequisite to school attendance in many locations. Requirements vary. The host country, host Rotary district and/or school may require additional immunizations. 申請者が接種した予防接種の日付を下記に明記してください。(日付は年-月-日で記載) 予防接種は、多くの地域で学校に通うための前提条件となっています。必須の予防接種の要件はさまざまです。受入国、地区、または学校から追加の予防接種を要求される場合があります。

Immunization	接種	Date #1	Date #2	Date #3	Date #4	Date #5	Date #6
DPT/DT	ジフテリア、破傷風、百日咳						
Rubella	風疹						
Mumps	おたふくかぜ						
Measles	はしか						
Poliovirus	ポリオ						
Chickenpox (Varicella)	水疱瘡						
Hepatitis B	B型肝炎						
Hepatitis A	A型肝炎						
Yellow Fever	黄熱						
Japanese Encephalitis	日本脳炎						
Meningococcal Meningitis	髄膜炎						
Typhoid	腸チフス						
COVID-19	メーカー-Manufacture ()						
Others (Specify)							
Additional Comments	追加のコメント 今後の接種予定等						

Tuberculosis screening: The applicant must present evidence of recent(within 3months) Mantoux/PPD skin test. 結核検査結果: 申請者は直近3ヶ月以内のマントー検査・PPD検査の結果を提出しなければならない。

Date of screening 診断日 (YYYY-MM-DD): _____ Result/diagnosis 診断結果 (Positive 陽性 / Negative 陰性)

If this result is positive or the applicant received a BCG vaccine, this is to certify that the above applicant has NO Tuberculosis because of the following examination's results 上記検査結果が陽性の場合またはBCG接種が申請者におこなわれた場合、下記検査により申請者が結核に感染していないことを証明する必要があります。

Examination for tuberculosis 結核検査	Result 診断	Date 診断日
<input type="checkbox"/> Chest X-ray: X線検査	Positive 陽性 / Negative 陰性	
	Comment 所見	
interferon-gamma release assay: IGRA インターフェロンγ遊離試験(どちらか)	<input type="checkbox"/> T-SPOT Positive 陽性 / Negative 陰性	
	<input type="checkbox"/> Quanti FERON-TB test(QFT) Positive 陽性 / Negative 陰性	

I, the undersigned, certify that the above Immunization Record is accurate. 上記予防接種の履歴および特定の感染性疾患の罹患歴にまちがいないことを証明します。

Physician address, phone and E-mail 病院の住所、電話、E-mail	Physician's Name 医師の氏名 <hr/> Signature 医師の署名 電子サイン(もしくは、紙にインクで書く) <hr/> Date of issue 日付 (年-月-日)
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Sponsor District: _____

Applicant Name: _____



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Section D: Dental Health and Examination

Dentist: This student is considering a year abroad as an exchange student. Insufficient, inadequate, or improper information about the student’s dental health, medications, or other problems could endanger this student while overseas. An immediate relative of the student may **not** complete the dental examination.

Use computer entry if possible. Consult Rotary Sponsor District Instructions for required copies and signatures. Print specified number of completed copies first for ink signatures on paper (if required). Electronic signature(s) may be applied last if both paper and electronic signatures are needed.

Full Legal Name as on passport or birth certificate (use uppercase for FAMILY name; e.g. John David SMITH)		Date of Birth (YYYY-MM-DD)		Male Female Non-Binary
Home Address – Street	City	State/Province	Postal Code	Country
Email Address	Home Phone Number		Mobile Phone Number	

Dental Examination

1. Is the applicant in good dental health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the applicant require dental work at this time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you foresee the applicant requiring any dental work while abroad?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain below (use space at bottom or additional pages if needed):		

Enter any additional comments below. (If additional pages are necessary, attach them and please check here)

CERTIFICATION

I certify that I hold a valid current license to practice dentistry and am not an immediate relative of the patient, and that I have personally examined the applicant and reported my findings as noted herein.

Dentist address, phone, fax and E-mail	Dentist Name
	Dentist Signature (ink on paper) or basic e-signature (using Fill & Sign); click only for digital signature
	Date (YYYY-MM-DD)