



Short-Term Exchange Program

Sponsor District _____

Health Declaration



Full Legal Name: _____

Do you have any mental health/medical/dental conditions?	Yes	No
Have you been treated for mental health/medical conditions in the past two years?	Yes	No
Have you taken any prescribed medications in the past six months?	Yes	No
Do you have any special health requirements (disabilities, allergies etc.)?	Yes	No

If you have answered 'YES' to any of the above please explain fully in the space below providing as much information as possible, including the name of any medication and the reason prescribed and include a copy of the doctor's prescription. Use additional sheets of paper if necessary.

I declare that I have stated my current health to the best of my knowledge.

Signature Date:

I agree that I am signing this document by keying my name: