

**Student Last Name(s):** \_\_\_\_\_ **First Name(s):** \_\_\_\_\_

**Address:**

House/Apartment # \_\_\_\_\_ Street \_\_\_\_\_  
 City \_\_\_\_\_ Province/State \_\_\_\_\_ Postal/Zip code \_\_\_\_\_ Country \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_  
 day / month / year

**EMERGENCY MEDICAL/DENTAL INSURANCE:**

**\*\* MANDATORY \*\***

All students must have adequate insurance coverage. Some school districts/schools require the student to be covered by the school issued insurance

Student will purchase insurance through:

**CISS MLI (unless mandatory through school)**

**On own\* (unless mandatory through school)**

\* if on own - CISS MLI will require a copy of the policy and student must have a credit card for up-front payments. The student must understand the process to apply for reimbursement.

Student wears **prescription glasses/contacts:** Yes No **Dental braces:** Yes No

**ALLERGIES:** Please list all allergies and the effects *(if more, please provide on separate page):*

Allergy	Reaction	Life-Threatening?		Medication
		Yes	No	
_____	_____	Yes	No	_____
_____	_____	Yes	No	_____
_____	_____	Yes	No	_____

Please list any medication(s) that the student should NOT take? \_\_\_\_\_

**A. HISTORY OF ILLNESS**

Does the student have, or has the student had, any of the following:

**Illnesses/conditions:**

**Disease, impairment or abnormality of:**

Yes	No		Yes	No		Yes	No	
		Allergies			Pertussis			Blood or Endocrine System
		Appendicitis			Pneumonia			Bones or Joints
		Appendix removed			Poliomyelitis (Polio)			Brain or Nervous System
		Asthma			Rheumatic Fever			Ears or Hearing
		Diabetes			Rubella (German Measles)			Eyes or Sight
		Diphtheria			Scarlet Fever			Genito-Urinary System
		Epilepsy			Smallpox			Heart or Blood Vessels
		Hepatitis (any form)			Tonsillitis			Lungs, Respiratory System
		Operation for Hernia			Tonsils removed			Other Abdominal Organs
		Malaria			Tuberculosis			Skin (Acne, Eczema, etc.)
		Measles			Typhoid			Stomach/Digestive System
		Migraines			Varicella (Chicken Pox)			Tonsils, Nose or Throat
		Mumps			Vertigo/Dizziness			
		Parasites			>> Other			

Please give a full description of any condition listed as YES, providing details for care/treatment and/or date of illness/last episode. A separate sheet can be attached: \_\_\_\_\_

**B. MEDICATION & PHYSICAL ACTIVITY**

- 1) Is the student currently taking medication for which a prescription is needed *(other than what is already listed for allergies)*  
 No      Yes      If yes, name: \_\_\_\_\_
- 2) Is the student currently taking medication for which a prescription is not needed? *(other than what is already listed for allergies)*  
 No      Yes      If yes, name: \_\_\_\_\_
- 3) Recommendation for general physical activity in school:  
 Full physical activity including physical education classes  
 Modified activity because of \_\_\_\_\_
- 4) If the student is eligible and wishes to participate in the high school competitive sports programme, is there any factor in the student's physical condition which might pose a problem for him/her?  
 No      Yes      If yes, explain: \_\_\_\_\_

**C. MENTAL & EMOTIONAL HEALTH**

1) **a** .Has the student ever been tested for or diagnosed with the following or anything similar:

<b>ADD</b> - Attention Deficit Disorder	No	Yes
<b>ADHD</b> - Attention Deficit Hyperactivity Disorder	No	Yes
<b>Dyslexia</b>	No	Yes

**b.** If yes to either one, please provide a full description including the date of diagnosis, the treatment, medications and self-help processes the student uses to control the disorder (a separate page may be attached).

\_\_\_\_\_

\_\_\_\_\_

2) **a.** Please check if the student suffers from or has at any point received medical counselling for any the following:

Depression	Severe Mood Swings
Anxiety Disorder	Learning Disabilities
Bipolar Disorder	Obsessive / Compulsive disorder
Eating Disorders	Tourette syndrome
Drug or alcohol dependency	Asperger's syndrome
Other mental, emotional or behavioural disorder: _____	

**b.** For those checked or listed, please provide a full description including the date of diagnosis, the treatment, medications and self-help processes the student uses to control the disorder or syndrome. A separate page or doctor's assessment may be attached.

\_\_\_\_\_

\_\_\_\_\_

3) Has the student ever inflicted or tried to inflict self-injury (suicide attempt, cutting)  
 No      Yes      Explain: \_\_\_\_\_

4) Has the student experienced any personal traumatic events that may cause emotional or behaviour issues (divorce, death in the family or of a friend, accident)      No      Yes      \_\_\_\_\_

5) Is there any cause to believe that any of the above listed disorders or syndromes will affect the student's ability to integrate into this programme, their host family or school life, or perform to the academic expectations of both the student's home school and Canadian host school?      No      Yes      Explain: \_\_\_\_\_

**D. HISTORY OF IMMUNIZATIONS/VACCINATIONS:**

**\* Please submit a copy of student's official immunization record \***

**IMMUNIZATION RECORDS will be reviewed by the school/school district and submitted to the provincial Health Unit. HEALTH UNIT may require missing immunizations be received either prior to arrival or once in Canada.**  
 NOTE: this list is accurate as of Sept 2020. Changes to required immunizations may be advised by provincial health units prior to student arrival.

1) Please indicate the **date, month and year** of all immunizations/vaccinations received by the student.

Vaccine	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)
<b>Mandatory for school attendance*</b>					
(last dose must be in last 10 years) <b>Diphtheria</b>					
(last dose must be in last 10 years) <b>Tetanus</b>					
(last dose must be in last 10 years) <b>Pertussis</b>					
(CHECK:    IPV    OPV) <b>Polio</b>					
<b>Measles</b>					
<b>Mumps</b>					
(German measles) <b>Rubella</b>					
2 types of <b>Meningococcal conjugate</b>	Type C		Type ACYW		
Students born in 2010 or later: (Chicken Pox) <b>Varicella</b>					
<b>Other (not mandatory)</b>					
<b>Human Papillomavirus (HPV)</b>					
<b>Haemophilus influenzae type B (Hib)</b>					
<b>Tuberculosis</b>	Mantoux		BCG **		

2) In the event that the health unit assigned to your child's file requires a mandatory vaccination, do you give permission for a health practitioner from the health unit to administer the vaccination to your child? CISS MLI will provide all necessary information and details prior to the appointment.

YES we agree to vaccinations being given in Canada

NO, do not provide vaccinations

\* Ontario requires all vaccinations listed under Mandatory. Other provinces strongly recommend vaccinations but may consider non-vaccinated students or students without all vaccines above. Non-vaccinated applicants must inquire first with CISS MLI.

\*\* The BCG vaccine may produce a positive result in a test for Tuberculosis. Canadian high schools may test incoming students for Tuberculosis, and the BCG is not a guarantee of immunity. Students testing positive for Tuberculosis may be required to have a chest x-ray or prove that he/she does not have Tuberculosis, or in some cases may be required to take medication. The cost of the x-rays or medication must be paid by the student as medical insurance will not pay these costs.

**FOR PHYSICIAN**

In my opinion, the general state of the student's health is:                      Excellent              Good              Fair              Poor  
 In my opinion, the general mental health of the student is:                      Excellent              Good              Fair              Poor

*I, the undersigned, have reviewed the medical history of the applicant including the immunization history listed above, have given a thorough physical examination of the applicant, and certify that all important medical information has been noted on this form and that nothing relevant has been omitted.*

Physician Signature:	Physician Seal or Stamp
Physician Name:	
Date:	
Physician Address:	



# HEALTH INFORMATION COVID

Have you been vaccinated?                    YES            NO

Have you received one dose or two doses?    one            two

Date for first dose (YYYY/MM/DD)    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Pfizer-BioNTec   Moderna   Astra-Zeneca   Johnson and Johnson   Other

If other, please indicate the name of the vaccine: \_\_\_\_\_

Date for second dose (YYYY/MM/DD)    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Pfizer-BioNTec   Moderna   Astra-Zeneca   Johnson and Johnson   Other

If other, please indicate the name of the vaccine: \_\_\_\_\_

Health Canada has approved vaccines for children aged 12 years and over. COVID Vaccines are now available in communities across Canada throughout the Provinces. The availability and timing for the vaccines in each community vary and depend on supply. The vaccination comes with several considerations including, but not limited to the following:

- Your child may experience adverse side effects from the vaccine;
- Canada currently recognizes 2 doses of the same vaccine as fully vaccinated;
- The vaccine offered to your child here in Canada may be produced by a manufacturer not available in your home country;
- Other unintended consequences not outlined on this form and unforeseen at this time.

For students who are not fully vaccinated:

If you choose to authorize your child to receive COVID vaccination in Canada, please fill and sign below:

We give permission for our child, \_\_\_\_\_ (Student Name), born on \_\_\_\_\_ (YYYY/MM/DD), to receive the COVID vaccine as it is made available within their community. We acknowledge that it is the responsibility of our son/daughter to register and attend the appointment. It is also his/her responsibility to collect and secure their own vaccine certificate or verification card.

By signing below, I confirm that I have read and understood vaccination information as provided on this page and confirm that I have discussed any risks, considerations, and side effects noted above. I am releasing and absolving MLI Homestay and my child's legal custodian from any claims, damages, or medical costs, resulting from the vaccine.

\_\_\_\_\_  
Parent 1 Name (printed)

\_\_\_\_\_  
Parent 2 Name (printed)

\_\_\_\_\_  
Parent 1 Name Signature

\_\_\_\_\_  
Parent 2 Signature

\_\_\_\_\_  
Date (DD/MM/YYYY)