CERTIFICATE OF HEALTH

(Please type or print)

Student's Name: _____

Home Address: _____

Telephone Number: _____

Date of Birth: _____

TO BE COMPLETED BY A MEDICAL DOCTOR

Has the applicant suffered from any of the following? Indicate by checking the box in the appropriate column for YES or NO.

	YES	NO		YES	NO
Allergies	___	___			
Appendicitis	___	___	Malaria	___	___
- has his/her appendix been removed?	___	___	Pneumonia	___	___
Asthma	___	___	Rheumatic Fever	___	___
Cancer tumours	___	___	Scarlet Fever	___	___
Convulsive Disorders	___	___	Tuberculosis	___	___
Diabetes	___	___	Typhoid Fever	___	___
Epilepsy	___	___	Typhoid Disease	___	___
German measles	___	___	Serious or Persistent Cough	___	___
Hepatitis	___	___	Serious or Persistent Headaches	___	___
Hernia	___	___	Migraine	___	___
- has he/she been operated for hernia?	___	___	Ulcer	___	___
- if yes, successful?	___	___	Vertigo, Dizziness	___	___
Any disease, impairment or abnormality of:					
Eyes or Sight	___	___	Other abdominal Organs (Liver, Kidney, etc)	___	___
Ears or Hearing	___	___	Skin (Acne, etc.)	___	___
Tonsils, Nose or Throat	___	___	Lungs, Respiratory System	___	___
Have his/her tonsils been removed?	___	___	Brain or Nervous System	___	___
Stomach or Digestive System	___	___	Blood or Endocrine System	___	___
Genito-Urinary System	___	___	Other _____	___	___
Heart or Blood Vessels	___	___			

Height _____ Weight _____

Pulse rate _____ Is pulse rhythm normal? _____

Blood pressure: Systolic _____ Diastolic _____

Are papillary and knee reflexes normal? _____

What is the applicant's vision: Without eyeglasses? OD _____ OD _____

With eyeglasses? OD _____ OD _____

Please give full information (including dates and details) about every disease or impairment mentioned in any of these questions.

_____

_____

Has the applicant ever been hospitalized? Yes ___ No ___

If yes, please give date, diagnosis and outcome of each illness or accident: _____

_____

_____

Is the applicant currently taking any oral medication? Yes ___ No ___ Injected medication? Yes ___ No ___
Other Medication? Yes ___ No ___
If yes, please give name(s) of medication(s), diagnosis and indicate when treatment will be discontinued:

_____

Does the applicant have a history or present evidence of nervous, emotional or mental abnormality? For example, is there any history of enuresis, nervous breakdown, nervous fatigue, recurrent nightmares, sleepwalking, stammering, stuttering or other similar conditions? Yes ___ No ___

If yes, please give details and current status: _____

_____

Does the applicant have a history or present evidence of any emotional or eating disorder? Yes ___ No ___

If yes, please give details and current status: _____

_____

Has the applicant ever consulted a neurologist, psychiatrist, psychologist or any other specialist in nervous or emotional or eating disorders? Yes ___ No ___

If yes, please give details: _____

_____

_____

Does the applicant have any health limitations or do you know of any pertinent medical information which is important for the International Program to know, should the applicant be considered for placement abroad? Yes ___ No ___

If yes, please comment fully: _____

_____

Will the applicant need any orthodontic care during the coming year? Yes ___ No ___

If yes, attach a statement from the orthodontists, indicating present status, exact care essential to the orthodonture and date care will be completed.

Has the applicant any history or present evidence of any allergy? Yes ___ No ___

Type of allergy (e.g. eczema, hives, hay fever, asthma or other) _____

_____

Allergen (food, drug, pollen or other) if known _____

Frequency of symptoms _____

Duration of symptoms (hours? Days?) _____

When were the last symptoms (month and year)? _____

Describe symptoms in detail and indicate severity _____

_____

_____

In the past year has the applicant received for the allergy(ies):
a) injected medications (give names, dosages and dates) _____

b) oral medication (give names, dosages and dates) _____

Please indicate any treatment for allergy(ies) expected during the coming two years by means of:
a) injected medications (give names, dosages and dates) _____

_____

b) oral medication (give names, dosages and dates) _____

_____

Has the applicant had asthma? (if so, give details and dates) _____

_____

When will allergy treatment and medication be entirely discontinued? _____

How long has the applicant been your patient? _____

In my opinion the general state of the applicant's health is (check one)

Excellent ___ Good ___ Fair ___ Poor ___

Comments: _____

_____

_____

_____ _____
Name of Physician (type or print) Degree

_____ _____
Address Street Date of examination

_____
Postal Zone City Country

Immunizations

The following Immunizations are the minimum required for acceptance into North American high schools. Depending on the individual school policy, further immunizations may be required

1. DIPTHERIA/TETANUS – 3 dates plus current booster within last 10 years.

_____	_____	_____	_____
month/day/year	month/day/year	month/day/year	month/day/year

2. POLIO – one of the two series of vaccinations: Trivalent Oral Polio Vaccine – 3 dates plus booster

_____	_____	_____	_____
month/day/year	month/day/year	month/day/year	month/day/year

OR Inactivated Polio Vaccine (Salk – 4 dates plus booster

_____	_____	_____	_____
month/day/year	month/day/year	month/day/year	month/day/year

3. MEASLES (Rubeola) – 2 dates, on or after first birthday

_____	_____
month/day/year	month/day/year

4. MUMPS – 2 dates, on or after first birthday

_____	_____
month/day/year	month/day/year

5. RUBELLA – 2 dates, on or after first birthday

_____	_____
month/day/year	month/day/year

6. HEPATITIS B – 3 dates

_____	_____	_____
month/day/year	month/day/year	month/day/year

Has this student received the BCG Vaccine for Tuberculosis No ___ Yes ___ : date ___/___/___ . If Yes, please note that this may produce a positive result in a test for Tuberculosis.

WE HEREBY CERTIFY THAT THE INFORMATION GIVEN IN THIS CERTIFICATE OF HEALTH IS COMPLETE AND ACCURATE TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

_____	_____	____ / ____ / ____
Signature of Physician	Name of Physician (print or type)	month day year

_____	____ / ____ / ____	_____
Signature of father or legal guardian	month day year	signature of mother or legal guardian

PERMSSION FOR MEDICAL CARE AND RELEASE

We, as the applicant's parents or legal guardians, agree to authorize the Custodial Parent to act for us in any emergency, accident or illness during the period of time the student is with the International Program. This covers the period from when the student boards transportation in the home country until the student leaves the return transportation in the home country.

_____	____ / ____ / ____	_____
Signature of father or legal guardian	month day year	signature of mother or legal guardian