HIGH SCHOOL APPLICATION

Student Last Name(s): _____

Student First Name(s): _____

Address: _____
street city

_____
state/province postal code country

Date of Birth: ___/___/___ day/month/year ***Weight***: _____ kg ***Height:*** _____ cm

A. HISTORY OF ILLNESS

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

Illnesses/conditions:

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 _____			

Disease, impairment or abnormality of:

Student wears **prescription glasses:** ○ Yes ○ No **dental braces**: ○ Yes ○ No

Please give a full description of any condition listed as YES, providing details for care/treatment and/or date of illness/last episode

_____

_____

_____

_____

ALLERGIES: Please list all allergies and the effects:

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

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

_____

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B. HISTORY OF IMMUNIZATIONS/VACCINATIONS:

1) Please indicate the **month and year** of all immunizations/vaccinations received by the student.
*Those with an ** must have occurred within the **past 10 years.***

Vaccine	Date	Date	Date	Date
Mandatory...				
Diphtheria**				
Tetanus/Toxoids (Td)**				
Pertussis				
Measles				
Mumps				
Rubella (German Measles)				
Other...				
Polio				
circle: **Hepatitis A / B or A & B**				
Varicella (Chicken Pox)				
Meningococcal C conjugate (Men-C)				
Human Papiloma Virus (HPV) *(girls)*				
Haemophilus influenzae type B (Hib)				
Tuberculosis (Manox Test)				
Other: _____				

2. Has this student received the **BCG Vaccine for Tuberculosis**? ◯ No ◯ Yes: date

Please note that this may produce a positive result in a test for Tuberculosis. Most Canadian high schools will test incoming students for Tuberculosis, and the BCG Vaccine 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.

C. 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 <u>not</u> 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: _____

D. MENTAL & EMOTIONAL HEALTH

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

ADD - Attention Deficit Disorder ◯ No ◯ Yes

ADHD - Attention Deficit Hyperactivity Disorder ◯ 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 been diagnosed with any of the following:

- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Eating Disorders
- ☐ Drug or alcohol dependency
- ☐ Severe Mood Swings
- ☐ Learning Disabilities
- ☐ Obsessive / Compulsive disorder
- ☐ Tourette syndrome
- ☐ Asperger 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. FOR PHYSICIAN

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

I, the undersigned, have reviewed the medical history of the applicant and given a thorough physical examination 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:		