Clear Content

MEDICAL HEALTH FORM

PUBLIC/PRIVATE DAY SCHOOLS: this form is mandatory
PRIVATE BOARDING SCHOOLS: school will have own form

Student Last Name(s): _____ ***First Name(s):*** _____

Address:

House/Apartment # _____ Street _____

City _____ Province/State _____ Postal/Zip code _____ Country _____

Date of Birth: ____ / ____ / ____ (day / month / year) ***Weight***: _____ kg ***Height:*** _____ cm

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 studdent must understand the process to apply for reimbusement.

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	

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:

Yes	No		Yes	No		Yes	No	Disease, impairment or abnormality of:
◯	◯	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: _____

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Student Name: _____

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 <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: _____

C. 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
Dyslexia	○ 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 councelling for any the following:

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

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: _____

_____

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Student Name: _____

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