Health Information Form

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GENERAL INSTRUCTIONS:

Thank you for taking the time to complete this form fully. The information it contains will help CISV to plan for your welfare and will assist any medical practitioners in the event that you should require their care during travel or the programme.

- Completing and having this is a condition of participation in CISV international Programmes
- Please complete this form in English either by typing or by hand, using black ink and in capital letters.
- This form must be **completed and signed not more than 3 months before participation** in the CISV International Programme.
- The information in this form is confidential. It will be destroyed as provided for by law.
- The only official text for this form is the English Edition.
- Please take the signed original of this form plus any supporting documents and one copy to the Programme, and leave one copy with the sending chapter.
- Parts A, B, C and D are to filled out by the adult (aged 21+) participant or by the parent/legal guardian of the youth (up to and including age 20) participant. If the law in your country does not allow parents to know the health information of their children aged 18+, then the individual should complete and sign these sections and note the age matter in the relevant box in section D.
- Part B – if there are any special needs or allergies, please send the contents of the Part B page to the Programme staff in advance of the Programme.
- Make sure to take the filled out sections A, B, C and D with you to the doctor, when going for the health check.
- Part E is the only part that must be completed by a doctor who meets with and conducts an appropriate health check on the participant.

Part A: PARTICIPANT INFORMATION

TO THE PARTICIPANT / PARENT / GUARDIAN: Please complete this form and review it with your physician during your consult.

Participant's Name: *Last* *First/Given* *Middle*		
Gender: ☐ Male ☐ Female	Date of Birth: __ __ __ __ __ __ __ __ *dd mm yyyy*	County of Citizenship:
Participant will attend CISV Programme in (Host Nation):	Duration of Programme (start date and end date): Start date: End date:	

In case of emergency, please contact:	Language(s) spoken:
Contact number (Home): - - *country code area code number*	Contact number (Office and/or Mobile): - - *country code area code number*

PART B: CURRENT MEDICATIONS AND NEEDS

If there are any special needs or allergies, please send this page (or send the information separately to the Programme staff in advance of the Programme.

Name of Participant:	
Sending National Association:	

Diet

Do you require a special diet?	Yes ☐ No ☐
If yes, please give details:	
Are there any foods that you cannot or should not eat?	Yes ☐ No ☐
If yes, please give details:	

Allergies

Do you have allergies to:

Food	Yes ☐ No ☐	*If yes, please specify:*
Bee stings or insect bites	Yes ☐ No ☐	*If yes, please specify:*
Medicines	Yes ☐ No ☐	*If yes, please specify:*
Others	Yes ☐ No ☐	*If yes, please specify:*
Do you have to carry an anaphylaxis-set with you?*	Yes ☐ No ☐	*If yes, please specify contents:*
What medications can you be given for an allergic reaction?		

If you need one, please remember to bring your anaphylaxis set with you.

Medications

Do you take any medications?

Brand Name	Generic Name	*Dose, Schedule, Special Instructions*	*Renewable Prescription?*
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Please ensure sufficient supply for the trip's duration.

Special Needs

Do you have any special needs or require any specific support? Yes ☐ No ☐

If yes, please specify:

Please bring any specific medical documentation (e.g. pathological findings in an electrocardiogram or x-ray) that would be very helpful for a doctor in the host country to have, should you require treatment. Bringing it with you can help avoid unnecessary and expensive procedures. It is recommended that you discuss this with your regular physician.

PART C: HEALTH HISTORY

In case of hospitalization by CISV, participant's medical records are available from:

Physician / Hospital:	
Telephone Number:	
Address:	

Has the participant ever had any infectious diseases? Please tick ☒ any that apply:

☐ Measles (Rubeola)	☐ Whooping cough (Pertussis)	☐ Hepatitis (specify)	☐ Frequent tonsillitis
☐ Mumps	☐ Scarlet fever (Scarlatina)	☐ Encephalitis	☐ Sinusitis
☐ Rubella (German measles)	☐ Rheumatic fever	☐ Yellow fever	☐ Bronchitis
☐ Chickenpox (Varicella)	☐ Otitis	☐ Malaria	☐ Pneumococcal infection
☐ Staphylococcal infection	☐ Streptococcal infection	☐ Other, please specify:	

Please provide a brief history/explanation regarding above and whether they have left any lasting complications:

Does the participant have any recurring medical problems or chronic conditions? Please tick ☒ any that apply:

☐ Anemia/blood disorder	☐ Eating disorder	☐ HIV	☐ Migraines / headaches
☐ Asthma	☐ Endocrine disorder	☐ Kidney disease	☐ Mobility limitations
☐ Autism/Asperger's Syndrome	☐ Diabetes	☐ Learning disability	☐ Musculoskeletal problems
☐ Autoimmune disorder	☐ Thyroid disease	☐ Mental health concern	☐ Neurological concerns
☐ Cardiovascular disease	☐ Eye disease*	☐ Anxiety	☐ Seizure disorder
☐ Heart murmur	☐ Gastrointestinal disease	☐ Depression	☐ Sleep disorder
☐ Hypertension	☐ Hearing problems	☐Psychotic illness	☐ Tuberculosis
☐ Attention deficit hyperactivity disorder (ADHD/ADD)	☐ Other, please specify:		

If you wear glasses or contact lenses, please bring a copy of your prescription to the Programme.

Please specify if there is anything that the Programme staff should be aware of relating to any of the above:	

Is there any family history of the following? Please tick ☒:

☐ Allergies or asthma	☐ Epilepsy	☐ Hypertension	☐ Migraines / headaches
☐ Diabetes	☐ Heart disease	☐ Mental health problems	☐ Skin diseases

☐ Other, please specify:

Please specify if there is anything that the Programme staff should be aware of relating to any of the above:	

In the past 5 years, has the participant ever been a hospital patient for any other condition? Yes ☐ No ☐

Date	*Diagnosis*	*Details*

For Female Participants:

Has the participant started menstruating?	Yes ☐ No ☐
If yes, is there any menstrual disorder?	Yes ☐ No ☐
What medication can be given for menstrual pain / dysmenorrhea?:	
Is the participant pregnant or is there a possibility that she may be pregnant?	Yes ☐ No ☐

Immunizations:

Please provide information on immunizations received:

Immunization	Yes	No	Date of inoculation or most recent booster	*Immunization*	Yes	No	Date of inoculation or most recent booster
DPT (Diphtheria, Pertussis, Tetanus)	☐	☐		MMR (Measles, Mumps, Rubella)	☐	☐	
Polio	☐	☐		Hepatitis A	☐	☐	
Measles	☐	☐		Hepatitis B	☐	☐	
Chickenpox	☐	☐		Influenza	☐	☐	
Meningococcal	☐	☐		Pneumococcal	☐	☐	
Tetanus	☐	☐		Other, please specify:			

Has the participant received all the necessary immunizations for travel to your host nation? Yes ☐ No ☐

Please give details below:

Immunization	Yes	No	Date
	☐	☐	
	☐	☐	

PART D - CERTIFICATION

I certify that all responses made on this form are true, accurate and complete, and I will notify CISV International of any relevant changes that may occur prior to or during my international Programme.

I consent to the release of medical information to CISV International or its agents so that they may provide me with needed assistance. I further agree that CISV International or its agents may release information to other persons who may need this information to assist me/the participant or to assist others in the Programme. I understand and agree that this form may be released to the host chapter or Programme director for such purposes.

If my parents or guardians have not signed this form, I represent and certify that I am not a minor according to the laws of my country.
Tick if this is the case ☐

Signature of Participant/ Adult Leader or Staff: _____ Date: _____

Signature of Parent/Guardian
of Participant/Junior Leader or Staff: _____ Date: _____

Part E: PHYSICIANS'S DECLARATION CONCERNING CISV PARTICIPANT

TO THE PHYSICIAN: The participant will take part in a CISV International Programme. Please consider the participant's general physical fitness and mental health in relation to the general requirements of Programme participation as will be explained to you by the participant or his/her parent/guardian. Please review the health information entered in Parts A, B and C and any other information you have available to you regarding the participant's medical history. This may include a physical examination if considered appropriate. Please discuss with the participant any medical advice and vaccinations necessary for travel to the host country. **The signing physician is responsible only for information entered in Part E of this form.**

☐ I am ☐ I am not	the participant's primary care physician.

I have reviewed the information provided above and verify it is consistent with the information available to me about the participant's medical history:	True ☐ False ☐
I have no information on or knowledge of the participant's medical history beyond what the participant has shown me in the above sections of this form	True ☐ False ☐

Comments:

The participant appears to be physically and mentally fit for travel to and participation in the CISV International Programme:	Yes ☐ No ☐
Physical examination performed:	Yes ☐ No ☐

Additional comments / relevant examination findings:

Is there any apparent evidence of alcohol and/or drug abuse?	Yes ☐ No ☐
Is there any apparent evidence of infectious disorders or diseases?	Yes ☐ No ☐

This participant may take part in all activities with the following *restrictions* or *recommendations*:	None ☐

Details on limitation of participation (if any):

TRAVEL MEDICINE

The participant has received appropriate advice on travel health relevant to travel to the host nation:	Yes ☐ No ☐
The participant has received all recommended immunizations for travel to the host nation:	Yes ☐ No ☐
The participant is receiving malaria prophylaxis for travel to the host nation (if necessary):	Yes ☐ No ☐

I certify that all information entered on this page of this form is true and accurate to the best of my professional knowledge.

Signature of Examining Physician: _____

Name of Examining Physician: _____

Date of Examination: _____

Physician Stamp or Business Card Here: