MEDICAL HEALTH

Clear Form

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

Date of Birth: ____ / ____ / ____ ***Weight***: _____ Kg ***Height:*** _____ cm
day / month / year

I/We confirm that the information on this Medical Health form is a true representation of my/our child's mental, emotional and phsycial health at the time of application. I/We understand that if his/her situation should change prior to arrival in Canada I/we must inform CISS of the changes, to enable CISS to confirm if any necessary support is possible.

Parent #1: _____ *Parent #2:* _____

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/Guard Me** **(unless mandatory through school)**

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	

Does student require use of an EPI-PEN for allergies? ○ Yes ○ No

Can student self-inject an EPI-PEN if possible? ○ 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:
		Appendicitis			Parasites			Blood or Endocrine System
		Appendix removed			Pertussis			Bones or Joints
		Asthma			Pneumonia			Brain or Nervous System
		Covid-19			Poliomyelitis (Polio)			Ears or Hearing
		Diabetes			Rheumatic Fever			Eyes or Sight
		Diphtheria			Rubella (German Measles)			Genito-Urinary System
		Epilepsy			Scarlet Fever			Heart or Blood Vessels
		Hepatitis (any form)			Tuberculosis			Lungs, Respiratory System
		Operation for Hernia			Typhoid			Other Abdominal Organs
		Malaria			Varicella (Chicken Pox)			Skin (Acne, Eczema, etc.)
		Measles			Vertigo/Dizziness			Stomach/Digestive System
		Migraines			>> Other			Tonsils, Nose or Throat
		Mumps			_____			

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. MENTAL & EMOTIONAL HEALTH

The mental and emotional well-being of students is of extreme importance to CISS. As custodians of the student, we need to meet the needs of each student at the academic, social and homestay level. Failure to disclose emotional or mental issues that affect your child is not only a disservice to everyone involved, but may lead to a withdrawal from our programme if the care of your child is found to be greater than what can be provided within our programme. We ask for honesty so we can accurately confirm support.

1) Has the student ever been tested for or diagnosed with a Cognitive Learning condition such as:

Yes	No		Yes	No	
		ADD - Attention Deficit Disorder			Dyslexia
		ADHD - Attention Deficit Hyperactivity Disorder			Disgraphia
		Other: _____			Discalculia

2) Does the student suffers from or has the student received counselling for:

Yes	No		Yes	No		Yes	No	
		Anorexia Nervosa			Bipolar Disorder			Obsessive-Compulsive Disorder
		Anxiety			Bulimia Nervosa			Orthorexia
		Asperger's Syndrome			Depression			Post-traumatic stress Disorder
		Autism Spectrum Disorder			Drug or alcohol dependency			Premenstrual Dysphoric Disorder
		Avoidant/Restrictive food intake disorder			Gender Dysphoria			Severe mood swings

☐ ☐ Any other mental, emotional or behavioural condition: _____

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

4) Has the student experienced any personal traumatic events that may cause emotional or behaviour issues (ex. divorce, severe illness or death in the family or of a friend, personal accident) ◯ No ◯ Yes:

_____

If any above is YES, a supplemental CISS Medical Details form will be required to provide full details, treatment plan and medications required currently and while in Canada. CISS reserves the right to impose conditions to a student's accept based on required support.

C. MEDICATION & PHYSICAL ACTIVITY

1) Other than medications for allergies already listed, is the student currently taking medication that will be required to be taken also in Canada? Please ensure all medications come with original label, dosage instructions and a translation into English.

◯ No ◯ Yes:

Name of medication	Is this prescription? or available in store?	Dosage

2.) **Recommendation for general physical activity in school or participation on a sport team?**

◯ Full physical activity including physical education classes with no issue or modifications

◯ Modified activity because of _____

MEDICAL HEALTH

D. HISTORY OF IMMUNIZATIONS/VACCINATIONS: * Submit a translated copy of student's official immunization record *

IMMUNIZATION RECORDS will be submitted to the provincial HEALTH UNIT in the city of study.
HEALTH UNIT may require missing immunizations be received or suspension may be issued until student is complaint.
Review may take place at any time during the school year, not necessarily at the start in September or February
NOTE: this is accurate as of February 2025. Changes to required immunizations may be advised by provincial health units anytime prior or during the student programme

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

Vaccine	Dose1 (dd/mm/yyyy)	Dose2 (dd/mm/yyyy)	Dose3 (dd/mm/yyyy)	Dose4 (dd/mm/yyyy)	Dose5 (dd/mm/yyyy)	Dose6 (dd/mm/yyyy)
Mandatory for school attendance*						
DTaP-IPV or individually +last dose must be in last 10 years Polio OPV may not be accepted — **Diphtheria+**						
Tetanus+						
Pertussis+						
Polio (☐ IPV ☐ OPV)						
MMR, MMRV or individually MMR: 1st dose no earlier than 12m old — **Measles**						
Mumps						
Rubella						
for students born 2010 or later **Varicella**						
2 types of **Meningococcal conjugate**		Type C	Type ACYW			
Other (not mandatory)						
Human Papillomavirus (HPV)						
Haemophilus influenzae type B (Hib) - may be part of DTaP-IPV-Hib						
COVID-19:						
Tuberculosis		Mantoux	OR	BCG **		

NOTES:
* **Ontario schools require 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.

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.

NOTE: failure to comply with the provincial vaccine requirements for province of study can lead to a mandatory suspension by the public Health Unit and School Board, until the vaccine requirements are met, or proof of immunity through a blood test is provided.

◯ YES we agree to vaccinations being given in Canada and will be in agreement with decisions made by CISS MLI

◯ NO, do not provide vaccinations
I will determine case-by-case our decision and understand there may be consequences for our choices if uncompliant

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. **If immunization record is incomplete** I have advised that vaccine or vaccine booster may be required, to meet the medical requirements in the province of study.

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