C H I L D R E N ' S I N T E R N A T I O N A L S U M M E R V I L L A G E S

AN INDEPENDENT, NON - POLITICAL, VOLUNTEER ORGANIZATION PROMOTING PEACE EDUCATION AND CROSS - CULTURAL FRIENDSHIP

CISV Health Form – HF 2000

Please complete in English either by typing or by hand in black ink, using capital letters). This form must be completed and signed no more than 3 months before participation in the CISV International programme. Please take the signed original to the programme along with one copy and leave a copy with the sending chapter.

Participant's family name: Gender: Male ☐ Female ☐

first / given names: Date of Birth: / / (dd mm yyyy)

Participant will attend CISV activity in (Host Nation):

Total days away from home:

In case of Emergency please contact:

Name: Language spoken:

Telephone (Home): / / (Codes: Nation Area number) Telephone (Office) / / (Codes: Nation Area number)

Physician's Declaration Concerning CISV Participant:

Height (cm) Weight (kg) Blood Pressure / Stomach Palpitation

Heart / Lung Stethoscopy Hernia: Yes ☐ No ☐ Menstrual Disorder: Yes ☐ No ☐

This CISV participant has received all recommended vaccinations for travel to the host nation: Yes ☐ No ☐

Is the general physical condition: Normal ☐ Abnormal ☐

Is the general emotional / mental condition: Normal ☐ Abnormal ☐

Is vision / hearing: Normal ☐ Abnormal ☐

Is the nutritional condition: Normal ☐ Abnormal ☐

Is there evidence of alcohol or drug dependence? Yes ☐ No ☐

Is there evidence of infectious disorders and / or sexually transmitted disease: Yes ☐ No ☐

Details of Abnormal findings and / or other comments (including past infections & chronic / recurring conditions):

Medication: (Prescription or over the counter / self-medication). **Please ensure sufficient supply for trip's duration.**

Is participant taking medication? Yes ☐ No ☐ If yes, state condition being treated:

Brand name	Generic Chemical Description	Dosage: Morning	Noon	Evening	Night	Renewable Prescription
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐

Medication Instructions (with / before / after meals, at bedtime, etc, and contraindications, not with food / alcohol, etc):

This Participant may take part in all activities with the following **Restrictions** or **Recommendations:** None ☐

Details of limitation on participation (if any):

Signature: (Examining Physician) Name (please print) (Examining Physician)

Date: / / (dd mm yyyy) I am ☐ am not ☐ the CISV participant's "usual" physician.

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

Name (please print): (Physician / Hospital) Telephone: / / (Codes: Nation Area Records Office)

NB: This information is confidential. It will be destroyed as provided by law. The only official text for this form is this English edition.

Carry this form with the relevant CISV Legal / Insurance Form – TWAL 2000, ALIF 2000 or YLIF 2000.

Parent / Adult Participant, please complete in English. For international use, please complete and carry official English language forms.

Participant's name: _____ Country: _____

Medical History: Apart from minor childhood illnesses, is the participant's health generally good? Yes ☐ No ☐

Yes	No	Year Booster	Infection History
☐	☐		Measles (Rubeola)
☐	☐		Mumps
☐	☐		Rubella
☐	☐		Chicken Pox (Varicella)
☐	☐		Whooping Cough (Pertussis)
☐	☐		Scarlet Fever (Scarlatina)
☐	☐		Rheumatic Fever
☐	☐		Otitis (inflammation of the ear)
☐	☐		Hepatitis (specify)
☐	☐		Meningitis
☐	☐		Yellow Fever
☐	☐		Malaria
☐	☐		Frequent Tonsillitis
☐	☐		Sinusitis
☐	☐		Bronchitis
☐	☐		Pneumococcal Infections
☐	☐		Streptococcal Infections
☐	☐		Staphylococcal Infections
☐	☐		Tuberculosis (TB) **Chest X-ray Result**

Immunization History:	Yes	No	Year
Measles (Rubeola)	☐	☐	
Mumps	☐	☐	
Rubella	☐	☐	
Chicken Pox (Varicella)	☐	☐	
Polio	☐	☐	
Diphtheria	☐	☐	
Tetanus Toxoid	☐	☐	
HNIG (human normal immunoglobulin)	☐	☐	
Hepatitis (specify)	☐	☐	
Meningitis (specify Hib ☐ or C ☐)	☐	☐	
Yellow Fever	☐	☐	
Malaria Prevention (specify)	☐	☐	
Typhoid	☐	☐	
Influenza (specify)	☐	☐	
Encephalitis (specify)	☐	☐	
Other (specify)	☐	☐	
Other (specify)	☐	☐	
Tuberculin (BCG)	☐	☐	

Alternative / additional TB test information (if any):

TB Test (tick ✓ below)	**Test Date**	**Result**
Mantoux / PPD ☐ **or** Heaf / Tine ☐		

Yes No Year Hospitalization History

☐ ☐ Diseases / injuries requiring X-ray examination (specify):

☐ ☐ Illnesses requiring hospitalization (specify):

☐ ☐ Injuries requiring hospitalization (specify):

Yes No Chronic Conditions & Recurring Medical Problems

☐ ☐ **01.** Drug reactions (specify drug & reaction, give details)

☐ ☐ **02.** Other allergic reactions (food, animal, plant, give details)

☐ ☐ **03.** Asthma or other lung / respiratory disorder (give details)

☐ ☐ **04.** Enuresis (bed wetting)

☐ ☐ **05.** Endocrinal disorder: Diabetes ☐ Thyroid ☐ (give details)

☐ ☐ **06.** Epilepsy

☐ ☐ **07.** Gynaecological / Menstrual disorder

☐ ☐ **08.** Kidney / stomach disorder (give details)

☐ ☐ **09.** Heart / blood pressure disorder (give details)

☐ ☐ **10.** Ear / nose / throat disorder (give details)

☐ ☐ **11.** Frequent Diarrhoea or Dysentery

☐ ☐ **12.** Sleep disorder

☐ ☐ **13.** Other disorders (give details)

☐ ☐ **14.** Emotional / behavioural counselling (give details)

☐ ☐ **15.** Wears braces or has "caps" / artificial teeth

☐ ☐ **16.** Glasses / contact lenses **(carry copy of prescription)**

☐ ☐ **17.** Physical limitations (give details)

☐ ☐ **18.** Special diet (give details)

Details (re past / chronic / recurring conditions)

Signature: _____ Date: / /

of Participant's Parent / Adult Delegate / Staff (as relevant) dd mm yyyy

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