



Diocese of Davenport

International Student Services Office

Certificate of Health

To be completed by Physician
Please type or print in **BLACK** ink

Note to physician: Please note that your complete frankness in completing this form is essential. If health problems which have a direct effect on a student's everyday health go unreported, the possibility exists that these could result in an early return for the student. In these cases, students do not receive a reimbursement of their fees. We appreciate your honesty. The physician cannot be a family member of the applicant.

Student Name: _____ Date of Birth: _____
Last First Day / Month / Year

HAS THE STUDENT EVER SUFFERED FROM OR HAD ANY PROBLEMS WITH THE FOLLOWING:

| DISEASES? | DATE | | |
|---|--------------------------|--------------------------|-------------|
| | NO | YES | MONTH/YEAR |
| Ashma | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Malaria | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Poliomyelitis | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Small Pox | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Typhoid Fever | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| If yes to any of the above, please explain: _____ | | | |
| _____ | | | |

| IMPAIRMENTS OR DISORDERS? | DATE | | |
|---|--------------------------|--------------------------|-------------|
| | NO | YES | MONTH/YEAR |
| Abdominal Organs | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Anorexia Nervosa | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Bones, Joint or Locomotor System | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Brain or Nervous System | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Bulmia | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Ears or Hearing | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Eating Disorder | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Heart or Blood Vessels | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Lungs, Respiratory System | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Persistent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Psychological/Emotional | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Speech | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| Vertigo, Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ |
| If yes to any of the above, please explain: _____ | | | |
| _____ | | | |

MEDICAL CARE HISTORY

Has the student ever been hospitalized? Yes No
If yes, please provide all details _____

Has the student ever been advised to have surgery which has not been done? Yes No
If yes, please provide describe: _____



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Is the student presently taking any medications or injections? Yes No

If yes, please list: _____

Has the student ever consulted with or been treated by a specialist for any of the following:

- | | | |
|---|------------------------------|-----------------------------|
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Substance Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia Nervosa | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychological/emotional illness such as depression, obsessive compulsive behavior, suicide attempts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, please provide all details _____

Are there any health restrictions or other pertinent medical information the Diocese of Davenport should know about? Yes No If yes, _____

ALLERGIES

Does the student currently suffer from allergies? Yes No

Type of allergy _____

Is he/she allergic to pets? Yes No

Can he/she live with pets? Yes No

Allergen if known _____

Year allergy started _____

When were the last symptoms? _____

Is there a history of allergies no longer active?

Have the allergic symptoms ever interfered with the patient's ordinary activities at home or at school?

Give details: _____

In the past year has the applicant received any medication for allergy?

List the medication: _____

When will allergy treatment and medications be entirely discontinued? _____

What medication, if any, should the applicant take while abroad? _____

HAY FEVER

Does the student have hay fever? Yes No

How would you describe the student's reactions to hay fever? Mild Strong Severe

There are few, if any areas of the United States that DO NOT have "hay fever" seasons. In your professional opinion, would this student be able to endure or control through medication(s) hay fever during his/her stay in the U.S.? Yes No



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DENTAL INFORMATION

Will the applicant need any orthodontic care during the coming year? Yes No

If yes, attach a statement from the orthodontist, indicating present status, exact care essential to the orthodonture, and date care will be completed.

GENERAL HEALTH INFORMATION

Height _____ Weight _____ Pulse Rate _____

Is pulse rhythm normal? Yes No Blood Type: _____

Blood Pressure: Systolic Diastolic

Is student physically able to participate in sports? Yes No

Limitations? _____ Comments: _____

Are pupillary and knee reflexes normal? Yes No Hearing normal? Yes No

What is the applicant's vision: Without glasses? OD _____ OS _____ With eyeglasses? OD _____ OS _____

How long has the applicant been your patient? _____

The general state of applicant's health is: Excellent Good Fair Poor

Name of Physician: _____

Degree _____

Address: _____

Phone: _____

I certify that I have examined this patient on this date and certify that all information provided in this certificate is accurate.

Signature of Physician: _____

Date: _____

IMMUNIZATION HISTORY

The immunizations listed below are required for all states in the USA. Physicians, please note: your country may have different requirements or restrictions on certain immunizations. Regardless of these, U.S. states and school districts do require the listed immunizations. If a student does not have these immunizations prior to their arrival, they will be required to get them before school enrollment. In addition, some school districts may require immunizations other than those listed below. Students will be required to meet all requirements and will be responsible for the costs of doing so.

| VACCINE | Date Each Does was Given | 1st | 2nd | 3rd | 4th | 5th |
|---|---------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | | Day/Mo/Year | Day/Mo/Year | Day/Mo/Year | Day/Mo/Year | Day/Mo/Year |
| POLIO (TOP) | | | | | | |
| *DPT AND/OR TD (Diphtheria, Tetanus and Portussis or whooping cough) OR (Tetanus and diphtheria only) | | | | | | |



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*Please note: In order to enroll in a U.S high school the student must have had a DPT or TD shot within the last 10 years. Requirements vary from state to state. Diocese of Davenport recommends 4 doses each of f Polio and DPT.

| VACCINE | <u>1st</u> Date Each Does was Given Day/Mo/Year | <u>2nd</u> Day/Mo/Year | <u>3rd</u> Day/Mo/Year |
|--|--|--------------------------------------|---|
| MEASLES (Rubeola – 10 day, red measles) | | | If no immunization, give date student had Rubella |
| RUBELLA (German Measles – 3 day measles) | | | If no immunization, give date student had Measles |
| MUMPS | | | If no immunization, give date student had Mumps |

| TUBERCULOSIS | DATE Day/Mo/Year | RESULTS |
|---|----------------------------|---|
| TB SKIN TEST (WITHIN ONE YEAR) | | <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ |
| BCG VACCINATION Did the student receive a BCG vaccination? (If yes, a chest x-ray is required) | If yes, date: | CHEST X-RAY DAY/MO/ YEAR If skin test is positive, chest x-ray is required |
| CHICKEN-POX (date of disease) | Day/Mo/Year | OR, Date of Chicken Pox Vaccination DAY/MO/YEAR |

| HEPATITIS B | | |
|--|-----------------------|-----------------------|
| <u>1st</u> | <u>2nd</u> | <u>3rd</u> |
| More states are requiring that foreign students have the vaccination for Hepatitis B. It is a three part vaccination. It is recommended that the student begin the vaccination procedure before arriving in the United States. | | |