



## 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?\* Please include non-prescription medications or remedies to avoid any misunderstanding.

Brand Name

Generic Name

Dose, Schedule, Special Instructions

If it is a prescription, is it renewable?

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:

<input type="checkbox"/> Measles (Rubeola)	<input type="checkbox"/> Whooping cough (Pertussis)	<input type="checkbox"/> Hepatitis (specify)	<input type="checkbox"/> Frequent tonsillitis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet fever (Scarlatina)	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Rubella (German measles)	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Yellow fever	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Chickenpox (Varicella)	<input type="checkbox"/> Otitis	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pneumococcal infection
<input type="checkbox"/> Staphylococcal infection	<input type="checkbox"/> Streptococcal infection	<input type="checkbox"/> 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:

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

<input type="checkbox"/> Allergies or asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Migraines/headaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental health problems	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>
If yes, is there any menstrual disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What medication can be given for menstrual pain/dysmenorrhea?	
Is the participant pregnant or is there a possibility that she may be pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)	<input type="checkbox"/>	<input type="checkbox"/>		MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>		Influenza	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>		Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>		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
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

**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 have included in this form, advised my CISV Chapter, my delegation Leader and the programme host Staff of any special needs or assistance that I/the participant may have relating to my/the participant's physical and mental health. I am aware that if I do not provide complete information, this may cause hardship and concern to others and may affect my/the participant's own welfare. I understand that if I do not provide complete information, CISV may decide to send me/the participant home from the programme at my/the participant's own expense.

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.

Signature of Participant/Junior Counsellor (age 16+) / Adult Leader or Staff:

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian of Participant/Junior Counsellor under age 18:

\_\_\_\_\_ Date: \_\_\_\_\_

## Part E: PHYSICIAN'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 \_\_\_\_\_ the participant's primary care physician.  
 I am not \_\_\_\_\_

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: \_\_\_\_\_

Physician's Stamp or Business Card here: