



# CHILDREN'S INTERNATIONAL SUMMER VILLAGES

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:			Night	Renewable Prescription
		Morning	Noon	Evening		
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>

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.**

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	Infection History
<input type="checkbox"/>	<input type="checkbox"/>		Measles (Rubeola)
<input type="checkbox"/>	<input type="checkbox"/>		Mumps
<input type="checkbox"/>	<input type="checkbox"/>		Rubella
<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox (Varicella)
<input type="checkbox"/>	<input type="checkbox"/>		Whooping Cough (Pertussis)
<input type="checkbox"/>	<input type="checkbox"/>		Scarlet Fever (Scarlatina)
<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>		Otitis (inflammation of the ear)
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis (specify)
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis
<input type="checkbox"/>	<input type="checkbox"/>		Yellow Fever
<input type="checkbox"/>	<input type="checkbox"/>		Malaria
<input type="checkbox"/>	<input type="checkbox"/>		Frequent Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>		Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>		Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>		Pneumococcal Infections
<input type="checkbox"/>	<input type="checkbox"/>		Streptococcal Infections
<input type="checkbox"/>	<input type="checkbox"/>		Staphylococcal Infections
<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis (TB)
			<b>Chest X-ray Result</b>

Immunization History:		Yes	No	Year	Booster
Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>			
Mumps	<input type="checkbox"/>	<input type="checkbox"/>			
Rubella	<input type="checkbox"/>	<input type="checkbox"/>			
Chicken Pox (Varicella)	<input type="checkbox"/>	<input type="checkbox"/>			
Polio	<input type="checkbox"/>	<input type="checkbox"/>			
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>			
Tetanus Toxoid	<input type="checkbox"/>	<input type="checkbox"/>			
HNIG (human normal immunoglobulin)	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis (specify Hib <input type="checkbox"/> or C <input type="checkbox"/> )	<input type="checkbox"/>	<input type="checkbox"/>			
Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>			
Malaria Prevention (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>			
Influenza (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
Encephalitis (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculin (BCG)	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Alternative / additional TB test information (if any):</b>					
<b>TB Test (tick ✓ below)</b>		<b>Test Date</b>	<b>Result</b>		
Mantoux / PPD <input type="checkbox"/> or Heaf / Tine <input type="checkbox"/>					

**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:** \_\_\_\_\_  
of Participant's Parent / Adult Delegate / Staff (as relevant)

Date:     /     /       
          dd   mm   yyyy