

Student Health Form

Today's Date:

To respond to the individual needs of our participants if the need arises, the student's parent or guardian is required to complete the following form. All information is confidential and may only be released to our Group Leaders and associated staff. In the event of an emergency, information provided will be shared with the appropriate medical authorities.

Student Name: _____ Gender: F M Birthdate: _____

Student Address: _____

Parent/Guardian Name(s): _____ Phone: _____

We require all students participating in the Student Exchange program to care for their recurring medical treatments without supervision. All medications, injections, or other treatments must be monitored and administered by the individual. Please further understand that we cannot control the contents of food products during travel. Should your child have dietary allergies, he or she is ultimately responsible for inspecting all food or ingredients related to the allergy.

The organizers of the Student Exchange are proud of our ability to provide reasonable accommodations as required by law. We have limited ability to meet such needs when we are not made aware of a condition or need for an accommodation in advance. Therefore, failure to disclose a medical condition that would require any accommodation on this medical health form may result in our inability to provide the accommodation. Should a student participate in our program without first disclosing such a need, it is understood that the student may be returned home at the sole expense of the parent/guardian.

Does your child have any of the following conditions or symptoms?

YES / NO		YES / NO	
An acute medical issue		Sever dental problems (not corrected by retainer, night guards, etc.)	
Seizures or epilepsy		Sever vision impairment (not corrected by glasses)	
Mobility limitations		Severe hearing impairment (not corrected by hearing aides/implants)	
Diabetes		Psychological conditions (e.g. depression, mood disorders, anxiety, eating disorders, etc.)	
Dizziness/fainting		Behavioral conditions (e.g. ADD, ADHD, ODD, PDD, etc.)	
High blood pressure		Head injury-concussion/loss of consciousness	
Heart Murmur		Racing/skipping heart beats	
Asthma		Trouble breathing during exercise	
Allergies		Frequent or severe headaches	
Kidney problems		Sickle-Cell Anemia	

If you answered "Yes" to any of the items above, please explain below (use additional pages as necessary).

Condition: _____ Detailed Description: _____

Medications (including vitamins, prescription medications & over-the-counter remedies): _____ None: _____

Describe in detail any medications or treatment your child will be using while on the trip.

Medication	Reason	Medication	Reason
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Allergies: _____ None: _____

Describe in detail all allergies (food, medications, etc.) and associated medications or treatment you child will be using on the trip.

Allergy:	Reaction:	Medication Required:	Life-Threatening:
..... <input type="checkbox"/>
..... <input type="checkbox"/>

For allergic emergencies, does your child carry an auto-injectable epinephrine (e.g. Epipen®)?

Dietary Restrictions:**None:**

Describe in detail any food restrictions or preferences for your child. We cannot guarantee certain meal requests, but will pass along this information to host families (and will try to pair students with families willing to accommodate such requests).

Additional description of relevant health conditions:**None:**

In the event that your child needs professional medical treatment during our program, please provide emergency contact and insurance carrier information and sign the release listed below which allows the sharing of medical information with our Group Leaders, host parents, and associated persons, as deemed necessary and appropriate.

Emergency Contact Information

Emergency Contact Name:

Relationship to Student:

Emergency Contact Phone 1:

Emergency Contact Phone 2:

Physician's Name:

Physicians Phone Number:

Insurance Information

Insurance Provider:

Insurance Contact Phone:

Name of Covered Member:

Group Number:

ID # for Student:

RX Group Number (if different):

Medical release, information sharing, and disclosure waiver

I, _____, parent or legal guardian of _____ do hereby recognize the need for my child to care for any recurring medical treatments without supervision. All medications, injections, or other necessary treatments will be monitored and administered by said child. I further understand the trip organizers cannot control the contents of food products during travel. If my child has dietary allergies, he or she is ultimately responsible for inspecting all food or ingredients related to the allergy.

Furthermore, I hereby give authorization to the group leaders and other staff related to the Student Exchange program and its representatives and agents to seek and provide medical services for my child when deemed appropriate. I also give authorization to any medical facility and medical staff to share personal medical information involving my child with any Student Exchange staff and/or its representatives and agents accompanying my child and/or the host parents, when deemed appropriate.

I hereby state that the information provided for my child on this form is true and complete. I recognize that failure to disclose a medical condition that would require any accommodation on this medical health form may result in the Student Exchange's inability to provide the accommodation. If this occurs, I release the Student Exchange group of all liability and understand that my child may be returned home, at their discretion, at my expense.

Signature (Student): _____

Date: _____

Print Name (Student): _____

Signature (Parent/Guardian): _____

Date: _____

Print Name (Parent/Guardian): _____