



**TARADALE HIGH SCHOOL**  
**Health Certificate for International Students**

To be completed and signed by the Student's physician. The physician should not be related to the student. Each question must be answered with a detailed explanation included or attached in a separate report for "YES" responses to questions 3-9, 11-13. Taradale High School reserves the right to ask for further information. The student and parent / guardian must also sign.

Student's Full Name \_\_\_\_\_ Home Country \_\_\_\_\_ Birthdate \_\_\_\_\_

1 Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_

2 Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration?  Yes  No If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**CHECK YES OR NO. HAS THE STUDENT HAD THE DISEASES / CONDITIONS LISTED BELOW:**

	YES	NO	IF KNOWN:		YES	NO
a) Measles	<input type="checkbox"/>	<input type="checkbox"/>	Titer: _____ Date: _____	h) Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
b) Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Titer: _____ Date: _____	i) Cough (persistent, recurring)	<input type="checkbox"/>	<input type="checkbox"/>
c) Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Titer: _____ Date: _____	j) Headaches (persistent, recurring)	<input type="checkbox"/>	<input type="checkbox"/>
d) Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		k) Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
e) Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>		l) Enuresis	<input type="checkbox"/>	<input type="checkbox"/>
f) Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		m) Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
g) Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		n) Parasites (internal)	<input type="checkbox"/>	<input type="checkbox"/>

If yes, give detailed information and dates (use extra pages if necessary): \_\_\_\_\_

3 **ACNE**  Yes  No If yes, identify area, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

4 **ALLERGIES**  Yes  No If yes, identify area, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

5 **ASTHMA**  Yes  No If yes, identify area, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

6 **DIABETES**  Yes  No If yes, identify area, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

7 **EPILEPSY or SEIZURE**  Yes  No If yes, identify area, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

\_\_\_\_\_

**8 HAS THE STUDENT EVER HAD ANY DISEASE, IMPAIRMENT OR ABNORMALITY OF:**

	YES	NO		YES	NO
a) Abdominal organs, digestive system	<input type="checkbox"/>	<input type="checkbox"/>	e) Heart blood vessels	<input type="checkbox"/>	<input type="checkbox"/>
b) Lungs, respiratory system	<input type="checkbox"/>	<input type="checkbox"/>	f) Tonsils nose or throat	<input type="checkbox"/>	<input type="checkbox"/>
c) Bones, joints, locomotor system	<input type="checkbox"/>	<input type="checkbox"/>	g) Blood, endocrine system	<input type="checkbox"/>	<input type="checkbox"/>
d) Genito-urinary system	<input type="checkbox"/>	<input type="checkbox"/>	h) Eyes / vision, ear / hearing	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain (use extra pages, if necessary): \_\_\_\_\_

\_\_\_\_\_

**9 HAS THE STUDENT EVER BEEN HOSPITALISED?**

Yes  No If yes, give dates, diagnosis and outcome for each incident. \_\_\_\_\_

\_\_\_\_\_

Student's First Name

Student's Family name

Home Country

10 Is the student currently taking medication or injections (other than those mentioned previously)?  Yes  No

If yes, identify the medication, reason for usage, dosage and frequency: \_\_\_\_\_

11 Has the student EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder?  Yes  No

12 Is there a history of, or present evidence of, an emotional, nervous or eating disorder?  Yes  No

If yes to either (12 or 13), a FULL report by the specialist and a statement by the student about the illness or specific problem must be attached in a sealed envelope.

Note: Living in a foreign country can be stressful. Please evaluate the student's condition and treatment along with his or her ability to manage this adjustment.

13 Are there any health limitations or restrictions on the student's activities and / or sports participation or any medical information which should be considered for a home/school placement?  Yes  No if yes, please describe: \_\_\_\_\_

14 Does the student wear glasses or contact lenses?  Yes  No

15 When was the date of the student's last dental check up? \_\_\_\_\_

Does the student wear braces?  Yes  No

If yes, will orthodontic care be needed while at Taradale High School?  Yes  No

**16 STUDENT HAS HAD THE FOLLOWING IMMUNISATIONS, PLEASE SPECIFY EXACT DAY, MONTH AND YEAR:**

	YES	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR
Measles	<input type="checkbox"/>	_____	_____	_____	_____	_____
Mumps	<input type="checkbox"/>	_____	_____	_____	_____	_____
Rubella	<input type="checkbox"/>	_____	_____	_____	_____	_____
Diphtheria	<input type="checkbox"/>	_____	_____	_____	_____	_____
Pertussis	<input type="checkbox"/>	_____	_____	_____	_____	_____
Tetanus	<input type="checkbox"/>	_____	_____	_____	_____	_____
Poliomyelitis	<input type="checkbox"/>	_____	_____	_____	_____	_____
BCG	<input type="checkbox"/>	_____	_____	_____	_____	_____
Hepatitis B	<input type="checkbox"/>	_____	_____	_____	_____	_____
Other	<input type="checkbox"/>	_____	_____	_____	_____	_____

TB Test Which type (circle one) Mantoux or Tine Date: \_\_\_\_\_ Result (+/-)

If positive, was chest x-ray done?  Yes  No Date: \_\_\_\_\_ Result (+/-)

I, the undersigned, certify that a thorough physical examination of the student has been given and all important recent medical information has been included on this form, and that the student is able to travel. I understand that the omission of any information could be harmful to the student's health care and could result in the student being sent home.

Physician Name

Signature

Date

Email

Phone

The parent and student's signatures below confirm that you understand and accept the Taradale High School Policies (as stated in the Tuition Agreement) and that the information on the Health Certificate is correct and complete.

Incomplete information could be harmful to the student's health care and could result in the student being sent home.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_