Youth Summit-Student Health Certificate

Student Name: ____ **DOB:** ______________
Surname First Name Middle DD/MM/YYYY

It is important that this form be filled out completely and accurately. THIS FORM MUST BE FILLED OUT IN ENGLISH.

Part A: I understand that the Summit does not cover costs associated with any medical care or treatment including, pre-existing conditions, accidents or sickness while traveling or while in the United States to participate in the Summit, dental work (including maintenance of orthodonture), or glasses. Students and natural parents are solely responsible for these costs. iEARN-USA strongly recommends that students and natural parents purchase travel insurance that the child may use while they are traveling to and/or in the United States.

Signature of Parent or Legal Guardian: __________________________________ **Date:** __________
Surname First Name Middle DD/MM/YYYY

Print Name: __________________________________
Surname First Name Middle

Part B: Has the student ever received treatment, attention, or advice from a physician or other practitioner for, or been told by a physician or practitioner, that s/he had (check yes or no);

(check one)	**Y**	**N**		**Y**	**N**
Asthma			Eye Abnormality or Disease		
Chronic or Recurrent Respiratory Disease			Hearing Impairment		
Disease or Abnormality of the Heart			Anorexia/Bulimia		
High Blood Pressure			Abnormal Weight Loss or Weight Gain		
Chronic or Recurrent Gastrointestinal Disorder			Psychiatric Problem or Illness		
Enuresis (Bed wetting)			Mental Health Concerns		
Chronic or Recurrent Kidney or Urinary Tract Disease			Reproductive System Abnormality or Disease		
Persistent or Recurrent Headache			Sexually Transmitted Diseases		
Seizure Disorder (Epilepsy)			Tuberculosis		
Thyroid Abnormality or Disease			Hepatitis A		
Diabetes Mellitus			Hepatitis B		
Other Endocrine Abnormality or Disease			Hepatitis C		
Chronic or Recurrent Arthritis			Measles		

(check one)	Y	N		Y	N
Muscle Disease or Skeletal Abnormality			Mumps		
Chronic or Recurrent Skin Condition			Rubella		
Cancer or Leukemia			Malaria		
			Other Childhood Diseases		

If you checked yes for any item above, please provide additional information (active or resolved, date of diagnosis, severity and frequency of condition, how does it affect the patient's daily life? Use additional paper if necessary:

Part C:
Do you have any allergies? (circle one) (Y/N) Is there a risk of anaphylactic shock? (Y/N) Have you ever been advised to carry an epi-pen? (Y/N) If yes, please describe your condition, how your symptoms present, and how you manage your condition.

Are you currently receiving on-going medical treatment of any condition, including antigen/immunotherapy injections or prescription medication? (Y/N). If yes, please provide details, whether you will require ongoing treatment while participating in the Youth Summit, and if so, how you plan to continue receiving this treatment.

Do you have a visual impairment that requires accommodation other than glasses or contact lenses? (Y/N)

Do you have a hearing impairment that requires accommodation? Y/N If yes, do you wear a hearing aid? Y/N

Do you have a physical disability or restriction on mobility for which you use an assist device, might need assistance, or might need accommodations? Y/N

If you answered yes to the above questions, please provide details on the impairment or restriction and any accommodations that might be needed:

Have you been hospitalized in the last 12 months? Y/N If yes, please provide details, including dates, and any ongoing care related to that event or condition:

Do you have any dietary restrictions, food allergies or other food-related restrictions or illness, including fasting requirements? Y/N if yes, please provide details, including how you are currently managing your health and any accommodations or support you may need while you are participating in the Summit:

Have you ever been diagnosed with or experienced depression; severe anxiety; drug/alcohol dependence; emotional, nervous, or eating disorders; or any mental illness? Y/N If yes, please provide additional information about your condition, including dates and durations of episodes and relevant treatment received. Indicate if you take medications fort his condition. Please discuss any accommodations or support that you may need while participating in the Summit. Please use additional pages if needed:

Do you wear orthodontic braces? Y/N If yes, will you require orthodontic care while participating in the Summit? Y/N

Do you currently have any dental problems, including unfilled cavities, impacted teeth, or abscessed teeth? Y/N

Declaration

The signatures below confirm that the student and parent(s)/legal guardian(s) authorize the release of medical information and the medical information made available in this form is correct and complete, and they understand that incomplete or inaccurate information could be harmful to the candidate's health care and could result in early dismissal from the Summit.

Signature of Parent or Legal Guardian: ____ **Date:** ___________
Surname First Name Middle DD/MM/YYYY

Print Name: ____
Surname First Name Middle