Student's Name_____

ASSIST

Today's scholars. Tomorrow's leaders.

Student Medical Information

All ASSIST students must have a **complete physical examination** within the **2018 calendar year** and must have received the necessary immunization vaccinations before they leave for the USA. Please read and complete the first page of this form, and have your physician complete pages three and four. After completion, make two copies of this form. **Send one copy to the ASSIST office in Connecticut, and send one copy directly to your school by July 1, 2018.** Bring the original with you to the ASSIST orientation in August.

Please note: Your school may require this medical information written on a school provided form. In this case, ASSIST will accept a copy of the completed school form for our files.

You will also need to access the **Parent Release for Medical Treatment & Emergency Medical Care.** A copy of this completed form should be mailed to the ASSIST office in Connecticut as well as your school when the copies of the Student Medical Information are sent. You should bring the originals with you to the ASSIST orientation in August.

Parent's/Guardian's Name: _____
(please print)

Home Address: _____ Tele: _____
Email: _____
_____ Mobile: _____

Business Address: _____ Tele: _____
Email: _____
_____ Mobile: _____

Emergency Information:

Home Physician: _____ Tele: _____

Home Physician's Address: _____

If unable to contact parents/guardian, please call:

Name: _____ Relationship: _____

Address: _____ Tele: _____

_____ Email: _____

Student's Name_____

Immunization Record

ASSIST and American secondary schools require that no student shall be admitted to a school without appropriate certification of immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, rubella, mumps, chicken pox and hepatitis A &B. It is also **required** that each student have a tuberculin test.

If you have not had these vaccinations/tests, you **must** receive them before you leave your home country. You will not be able to participate in any activities, including orientation, unless the certification for all of them is on file with ASSIST and your school. Documentation must include the **month, day and year** administered.

The following vaccinations are required:

1. Tuberculosis

In addition to required vaccinations, you must have a tuberculosis (TB) skin test using the Intradermal Mantoux or the QuantiFERON-TB Gold Test (QFT-G blood test)- not a multiple puncture. **If you have received BCG or had a positive skin test, you need to have either the QuantiFERON blood test or a CXR report (x-ray) to show that your lungs are healthy. Without this verification, you <u>WILL NOT</u> be allowed to attend school in the US. The date of the TB test can be <u>NO</u> earlier than July 2017. If the date of the test is earlier than July 2017, it <u>MUST</u> be re-taken.**

2. DPT: Diphtheria, Pertussis (Whooping Cough), Tetanus

You must have received three (3) or more doses of DPT, with the last dose being a booster and having been received on or after the fourth (4^{th}) birthday. If ten (10) years have elapsed since the last booster, a Tetanus, Diphtheria and Pertussis (TDaP) booster shot is required. Most schools will require the Pertussis vaccine be included in this booster, so a TD vaccine only will not be accepted. Please request that TDaP booster specifically and mark it on the form.

3. Polio

You must have received three (3) or more doses of Trivalent Oral Polio (Sabin) Vaccine (TOPV) with the last dose being a booster and having been received on or after the fourth (4^{th}) birthday. The first two (2) doses must be separated by at least six weeks. A series of Inactivated Polio Virus (Salk) Vaccine (IPV) and appropriate boosters may be substituted for vaccination with the TOPV at the direction of a physician.

4. **Measles**

You must have received two (2) doses of Live Measles Virus Vaccine. The first dose must be after one (1) year of age, and the second no less than one month later. A proof of disease, verified with the date of illness and signed by a physician, or laboratory evidence of any detectable level of antibody is acceptable instead of immunization.

5. Rubella (German Measles)

You must have received one (1) Rubella vaccination after one (1) year of age. Proof of disease is not acceptable unless laboratory evidence is presented with any detectable level of antibody.

6. Mumps

You must have received one (1) Mumps vaccination after one (1) year of age. Proof of disease verified by a physician is acceptable instead of immunization.

7. Varicella (Chicken Pox)

You must have had a vaccination or provide the date the student had the disease. The vaccination requires two (2) shots, at least one month apart.

8. Hepatitis A

This vaccination series is recommended for administration at least 1 year old. Over 18 years old, a booster series is required. This two shot series should be administered at least 6 months apart.

9. Hepatitis B

This vaccination is required in most US schools. It is recommended that the first dose be given at 11-12 years. A booster dose is expected at 16 years old. This vaccine requires a series of three shots administered over an extended period of time. After the first shot, the second shot should be administered one month later. The third shot should be administered six months after the first shot is received. **Please make arrangements as soon as possible to begin this process.**

10. Meningitis

This vaccination is required in all Boarding Schools; and most Day Schools recommend it. If you will attend a Day School, please check with your school to learn if this vaccination is required.

Student's Name_____

Student Birth date (Month/Day/Year) _____

The following information must be completed by your physician:

Date of physical examination (Month/Day /Year): _____

Immunizations: Please record **COMPLETE** dates (**Month/Day/Year**) of vaccine doses administered.

Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTP)					
Diphtheria/Tetanus/Pertussis (TDaP booster)					
Poliomyelitis (TOPV or IPV)					
Measles (Rubeola)					
Mumps					
Rubella					
Measles, Mumps, Rubella (MMR)					
Hepatitis A					
Hepatitis B					
Chicken Pox					
Meningitis					

Disease Verification – Indicate date (Month/Day/Year) and attach verification:

Measles _____ Mumps _____ Rubella _____ Chicken Pox _____

❑ **Mantoux Tuberculosis (TB) Skin Test**:

Date:_____Results (check one): NEGATIVE ____ POSITIVE ____ , if positive, **Chest X-ray required**.

Or

❑ **QuantiFERON-TB Gold Blood Test**

Date:_____Results (check one): NEGATIVE ____ POSITIVE _____, if positive, **Chest X-ray required**.

If results are positive, or if the student has received BCG, you **must** have the QuantiFERON Gold Blood test or attach a copy of the CXR report (x-ray) to prove that the lungs are healthy. Students will not be allowed to participate in the exchange year unless this is complete.

Medical History

1. During the past five years, when and for what injury or illness (including any of the following) has the student been under observation; had medical or surgical advice or treatment; been hospitalized? Give: (1) specific name of illness, (2) duration – specify date, (3) final results. If none, write "None."

_____

_____

_____

2. Is there any history of adverse reaction to anesthesia? (Please describe):

_____

_____

Student's Name_____

3. Has the student ever received treatment or counseling for an emotional or psychological problem?

Yes ___ No____ If yes, when? _____ Please explain: _____

_____

_____

4. Height _____ Weight _____BMI_____

5. Do you consider the student physically and emotionally able to carry on a full course of activity and study in an educational institution abroad? Yes _____ No _____

3. In your opinion, is the student's health and physical condition (circle one)
EXCELLENT GOOD FAIR POOR.
Please specify reason for FAIR or POOR rating, if not documented elsewhere.

_____

_____

7. How long have you known the student? _____

8. Please add any other information, whether or not it is requested on this form, which might be pertinent to the student's medical profile.

_____

9. If the student is required to take any medication, please give full details about the reason for the medication; what it is and when it needs to be given to the student.

_____

10. Please indicate with an "X" if student has ever had a problem in the following areas, and give full details:

Asthma		Orthopedic Injuries/Surgery		Eyes, Ears, Nose, Throat	
Sinusitis		Pneumonia		Allergies	
Hay Fever		Tuberculosis		Kidney/Bladder Problems	
Eating Disorders		Abnormal Blood Pressure		Menstrual Problems	
Cancer		Heart Disease or Disorder		Headaches/Seizures	
Malaria/Fever		Diabetes		Attention Deficit Disorders	
Intestinal Disorder		Tonsillitis		Hepatitis	
Dizziness/Fainting		Anxiety/Panic Disorders		Depression	

Details:

_____

Signature of Physician: _____Date: _____

Physician's Name and Address (Please print): _____

_____

_____