Health Examination Record

Student Name:		
Date of Birth (MM/DD/YYYY):	Age:	Male or Female

Health History:

Abnormal Menstruation/PMS		Convulsions		Frequent Ear Infections		Mumps	
Allergies		Diabetes		German Measles		Plant Poison (Ivy, Sumac)	
Arthritis		Disability (specify)		Hay Fever		Psychiatric Treatment	
Asthma		Drug Allergy (specify)		Heart Disease/Defect		Rheumatic Fever	
Autism		Eating Disorder		Hypertension		Sleeping Disorder	
Bedwetting		Emotional Behavior		Insect Stings (specify)		Tuberculosis	
Bleeding/Clotting Disorder		Epilepsy		Kidney		Other/Specifications:	
Chicken Pox		Fainting		Measles			
Constipation		Food Allergy (specify)		Mononucleosis			

HAS THE STUDENT HAD ANY CHRONIC CONDITIONS SUCH AS DIABETES, ASTHMY, ALLERGIES, ETC?	Y	N
HAS THE STUDENT HAD MAJOR SURGERY, A SERIOUS ACCIDENT OR ILLNESS?	Y	N
HAS THE STUDENT HAD ANY PSYCHOLOGICAL, NEUROLOGICAL OR EMOTIONAL DISORDERS?	Y	N
HAS THE STUDENT EVER BEEN DIAGNOSED WITH ATTENTION DEFICIT (ADD/ADHD) DISORDER OR SIMILAR CONDITION?	Y	N
HAS THE STUDENT EVER SUFFERED FROM EPLIEPTIC SEIZURES OR A SIMILAR CONDITION?	Y	N
WILL THE STUDENT BE TAKING ANY MEDICATION DURING HIS/HER STAY (PLEASE LIST BELOW)	Y	N
IS THE STUDENT ON A RESTRICTED DIET FOR MEDICAL OR OTHER REASONS (VEGETARIAN, CELIAC, ETC)?	Y	N
ARE THERE ANY ACTIVITIES OR SPORTS DISCOURAGED FOR MEDICAL OR OTHER REASONS?	Y	N
DOES THE STUDENT SUFFER FROM ANY PHOBIAS, BEHAVIORAL ISSUES OR EATING DISORDERS	Y	N
HAS THERE BEEN ANY SIGNIFICANT CHANGES AT HOME OR SCHOOL DURING THE PAST THREE YEARS?	Y	N
IS THE STUDENT CURRENT ON ALL IMMUNIAZTIONS. DATE OF MOST RECENT TETNUS (MM/YYYY)	Y	N
IF YOU MARKED "YES" TO ANY OF THE QUESTIONS ABOVE, PLEASE EXPLAIN:		

I, as the guardian of _____, do hereby authorize Compass USA and it's representatives, to be identified later by Compass USA, to consent to any x-ray examination, anesthetic medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general supervision of any licensed physician or surgeon, whether such diagnosis or treatment is rendered at the clinic of said physician or surgeon or at a hospital. It is understood that authorization is not given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on their part to give specific consent to and all such diagnosis, treatment or hospital care which the aforementioned physician or surgeon in the exercise of his or her best judgement may deem advisable. It is understood that this authorization is being given to Compass USA prior to the selection of a homestay family for my child, and that I consent to this homestay family and/or Compass USA representatives providing authorization for medical care for my child as described by this authorization. I certify that the above information is correct to my knowledge.

Print Parent Name_____

SIGNATURE: _____ DATE: _____
(Parent/guardian)

Emergency Contact:	Relationship to Student:	Cell Phone Number: