Health Form

Fax or E-mail to: Concordia Language Villages
901 S. 8th St, Moorhead, MN 56562
Fax: 1 218-299-3807
E-mail: clvcorp@cord.edu

Session (check one): ❑ EE52  ❑ EE72  ❑ EE53  ❑ EE73

H H o m e t o w n ,  E u r o p e  2 0 0 4

Health History:
The Health History must be completed by the parent/guardian within six months of program participation. Provide adequate information so the Language Villages can work effectively with your child. Email or fax the completed form to the Language Village office at least two weeks before the start date of your program and bring the signed original to Opening Day with your child. Keep a copy of the completed form for your records; note changes and inform the village Dean in writing of any changes.

NOTE: There is no nurse or physician on our staff. Your child will be referred to a local provider if medical care is needed and you will be billed for this.

Allergies: Initial those that apply to this villager.

❑ This villager has no known allergies.

❑ This villager has a food allergy to (name the food/s):
____________________________________________________________________________________
____________________________________________________________________________________

❑ This villager is allergic to this medication/s:
____________________________________________________________________________________

❑ This villager is allergic to these substances:
____________________________________________________________________________________

Describe the reaction and what is done to manage it (attach additional information if needed):
____________________________________________________________________________________
____________________________________________________________________________________

Diet: Initial those that apply to this villager.

❑ This villager eats a regular diet and has been prepared to eat foods of different countries.

❑ This villager has the following diet restriction(s):
  ❑ Needs a meal plan that supports his/her diabetes.
  ❑ Will die (anaphylaxis) if s/he eats this food:

❑ This villager prefers a vegetarian option.

Chronic Concerns: Initial all that pertain to this villager and provide information about supportive healthcare.

❑ This villager has no chronic health concerns and is capable of full participation in the program.

❑ This villager has the following chronic health concern(s):
  ❑ Asthma
  ❑ Diabetes
  ❑ Frequent ear infections
  ❑ Headaches
  ❑ Bedwetting
  ❑ Frequent colds
  ❑ Sleepwalking
  ❑ Menstrual Cramps
  ❑ Other

Provide information about supportive healthcare needed for each initialed item: ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
**Medication:** Provide complete information. **NOTE:** Your villager is responsible for self-medicating. Bring enough medication to last the entire session. Prescription medications MUST be in pharmacy containers and appropriately labeled.

___ This villager does not take any medication on a routine basis.

___ This villager takes routine medication (include vitamins) as follows (attach more information if needed):

<table>
<thead>
<tr>
<th>Name of medication:</th>
<th>Name of medication:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for taking:</td>
<td>Reason for taking:</td>
</tr>
<tr>
<td>Dose taken:</td>
<td>Dose taken:</td>
</tr>
<tr>
<td>How often each day?</td>
<td>How often each day?</td>
</tr>
</tbody>
</table>

**Immunization History:** Provide the month and year for each immunization. Starred (*) immunizations must be current.

<table>
<thead>
<tr>
<th>Starred (*) Immunization</th>
<th>Immunization</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps, Measles, Rubella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenza B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General History:** *Circle “YES” or “NO” for each statement.*

YES NO This villager has had chicken pox.

YES NO This villager has not had mononucleosis in the past twelve months.

YES NO This villager has no history of illness, injury or surgery, which would affect participation.

YES NO For girls: This villager knows about menstruation and has a normal menstrual history.

Use this space to explain statements for which “NO” was circled: __________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

Name of villager’s physician: __________________________ Office Phone: (____)____________ Country: __________________________

If your child receives care for emotional, learning, and/or psychological concerns, provide information to help us work effectively with him/her: __________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

Use this space to provide additional information about your child’s health: __________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

**Billing Information for Healthcare:** Parents/guardians are financially responsible for healthcare given by a provider.

Where should the bill for your villager’s healthcare be sent?

Name: __________________________________________ Address: __________________________________________

If the Language Villages incurs a charge for your child’s healthcare, we will bill you.

**Parent Contact Information:** We will call in an emergency or if we have questions about your child. Please provide contact information as well as information for one other person should we be unable to reach you.

<table>
<thead>
<tr>
<th>Contact Parent:</th>
<th>Daytime Phone: (____)</th>
<th>Evening Phone: (____)</th>
</tr>
</thead>
</table>

E-mail Address for Parent: __________________________

<table>
<thead>
<tr>
<th>Alternate Contact:</th>
<th>Daytime Phone: (____)</th>
<th>Evening Phone: (____)</th>
</tr>
</thead>
</table>
Parent/Guardian Authorization for Healthcare: This health history is correct, and the person described has permission to participate in all village activities except as noted by me and/or the examining physician. I give permission to the treating physician to order x-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. This form may be photocopied.

Signature of Parent/Guardian: ____________________________________________ Date: ________________________

Medical Recommendation: The Medical Recommendation should be completed by a licensed physician or nurse practitioner and based on an examination done within the past two years.

Physicians: There is no nurse or physician in residence with the program. The village’s Dean and designated first aide will use this information to determine program needs and will bring the information to a physician should the child need referral.

Date this information was completed: __________________________

Height: __________________________
Weight: __________________________
Blood Pressure: __________________________

This person is under the care of a physician for the following: __________________________

Treatment to be continued during the trip for this person: __________________________

Medication(s) to be taken by this person while at the Village (provide medical order for administration): __________________________

This person is allergic to the following: __________________________

Treatment for allergic response: __________________________

List activities in which this person should not participate or have limited participation (describe the limitation): __________________________

Additional health information needed for a successful experience: __________________________

MD/NP Signature: __________________________ Office Phone: (______)__________________________
Address: __________________________

Date/Time Language Village Notes Initial

SCREENING must be conducted and significant findings noted.

Signs/symptoms of illness or injury upon arrival? YES as noted below
History of exposure to communicable disease? YES as noted below
Additions or corrections to information on health history? YES as noted below
Routine medication used by the participant? YES as noted below
EXIT NOTE – Check one of the following

- [ ] Left program this day with no reported illness or injury symptoms......... Initial: __________________________
- [ ] Left program this day with the following problem/concern:............................. Initial: __________________________

This problem was referred to (name of responsible person): __________________________

________________________________________________________
________________________________________________________