**Health form**

This health form is composed of two parts: Part 1: Medical opinion on pupil's suitability for participation and Part 2: Health information form. Part 1 will be completed and signed by the doctor, printed and transmitted to the sending school in order to confirm the pupil's selection for the participation in the long term study mobility. Part 2 will be completed by the doctor, signed by parents/guardians and the pupil, and put in a sealed envelope. The pupil will bring it with him or her and it will only be opened by a doctor treating the pupil and when medically necessary.

**Part 1: Medical opinion on pupil's participation**

This part of the document will be printed and transmitted to the sending school in order to confirm the pupil's selection for the participation in the long term study mobility. I, the undersigned, certify that a thorough physical examination of the pupil has been made and all relevant medical information has been included in the Health form, and that the pupil is able to travel. I understand that the omission of any information could be harmful to the pupil’s health care and could result in early termination of the stay. I consider that, in the light of the pupil’s medical and/or psychological history, he/she **is / is not** (delete whichever does not apply) able to take part in the long term study mobility of pupils in the framework of the Erasmus+ programme.

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| --- | --- |
| Doctor’s Name and Degree: | Stamp and Signature: |
| Contact details (address, phone, e-mail if applicable): | Date: |

**Part 2: Health form**

The pupil is considering spending between 2 and 12 months in a school abroad and living with a host family. Incorrect or incomplete information on his/her health could lead to problems during the stay. The form must be completed by the pupil’s doctor who is not an immediate relative of the applicant. The pupil’s parent(s)/guardian(s) should provide the doctor with all relevant information/documentation on the pupil’s medical history. If the answer to any of the questions 3-14 is ‘YES’, please include or attach detailed information. This health form will be put in a sealed envelope. The pupil will bring this form with him/her. The envelope can only be opened by a doctor treating the pupil where medically necessary.

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| --- | --- | --- |
| Pupil Name: | Home Country: | Date of birth: |

**1.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Height |  | Weight |  | Blood pressure |  | 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

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| --- |
| If yes, explain: |

**3.** Tick yes or no. To your knowledge, has the pupil had the disease/conditions listed below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| a) Measles |  |  | j) Rheumatic Fever |  |  |
| b) Mumps |  |  | k) Cough (persistent, recurring) |  |  |
| c) Rubella |  |  | l) Headaches (persistent, recurring) |  |  |
| d) Chicken Pox |  |  | m) Sleepwalking |  |  |
| e) Poliomyelitis |  |  | n) Enuresis |  |  |
| f) Hepatitis |  |  | o) Appendicitis |  |  |
| g) Tuberculosis |  |  | p) Parasites (internal) |  |  |
| h) STD |  |  | q) Encephalitis |  |  |
| i) FSME |  |  | r) Scarlet fever |  |  |

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

**4.** ACNE: yes no

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| --- |
| If yes, identify area, severity, any medication taken, name, dosage & frequency: |

**5.** Allergies: yes no

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| --- |
| If yes, identify type, any medication taken, name dosage & frequency: |

**6.** Asthma: yes no

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| --- |
| If yes, identify type, severity, any medication taken, name, dosage & frequency: |

**7.** Diabetes: yes no

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| --- |
| If yes, identify type, severity, any medication taken, name, dosage & frequency: |

**8.** Seizure disorder: yes no

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| --- |
| If yes, identify type, severity, any medication taken, name, dosage & frequency: |

**9.** Has the pupil ever had or does today's examination show any disease, impairment, or abnormality of:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| a) Abdominal organs, digestive system |  |  | e) Heart blood vessels |  |  |
| b) Lungs, respiratory system |  |  | f) Tonsils, nose, or throat |  |  |
| c) Bones, joints, locomotor system |  |  | g) Blood, endocrine system |  |  |
| d) Genito-urinary system |  |  | h) Eyes/vision, ear/hearing |  |  |

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| If yes, please explain (use extra pages, if necessary) and specify if any aids, adaptations or special assistance are required: |

**10.** Has the pupil been hospitalised? yes no

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| If yes, give dates, diagnosis and outcome for each incident. |

**11.** Is the pupil currently taking medication or injections (other than those mentioned previously)? yes no

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| --- |
| If yes, identify the medication, reason for usage, dosage and frequency: |

**12**. Has the pupil EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder? yes no

**13.** 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 parents about the illness or specific problem must be attached.** Note: Placement in a foreign host family, school and community requires adjustment which often involves emotional stress. It will not be a time for relaxation or temporary relief from any current therapy. If the pupil is experiencing current emotional, physical, personal or family difficulties, these difficulties can be severely exacerbated by the adjustment demands of the programme. Therefore, you are requested to evaluate carefully the pupil’s current or previous condition and treatment along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

**14.** Are there any health limitations or restrictions on the pupil’s activities and / or sports participation or any medical information which should be considered for a home/school placement? yes no

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| If yes, please describe: |

**15.** Does the pupil wear glasses or contact lenses? yes no

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| --- |
| If yes, please give the lens power: |

**16.** What was the date of the pupil’s last dental check-up?

Does the pupil wear dental braces? yes no

If yes, will orthodontic care be needed during the stay abroad? yes no

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| Frequency? |

**17**. Confirm if the pupil has had the following immunisations. If yes, specify the day, month, and year (or, if possible, attach a copy of vaccination card):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Ja** | **Nein** |  | **Ja** | **Nein** |
| Measles |  |  | Tetanus |  |  |
| Poliomyelitis |  |  | Mumps |  |  |
| BCG |  |  | Rubella |  |  |
| Hepatitis B |  |  | Diptheria |  |  |
| Pertussis |  |  | Other |  |  |

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| --- |
| If other, please specify: |

**18.** If the pupil has had the TB Test, please specify the type:

Mantoux or Tine (circle one)

Date: \_\_\_\_\_\_\_ Result (+/-): \_\_\_\_\_\_

If positive, was a chest x-ray done?

yes no Date: \_\_\_\_\_\_\_\_ Result (+/-)

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| --- |
| If yes, please explain (use extra pages, if necessary): |

**Signatures:**

I, the undersigned, certify that a thorough physical examination of the pupil has been made and all important recent medical information has been included in the Health form, that nothing relevant has been omitted, and that the pupil is able to travel. I understand that the omission of any information could be harmful to the pupil’s health care and could result in early termination of the stay.

|  |  |
| --- | --- |
| Doctor’s Name and Degree: | Stamp and Signature: |
| Contact details (address, phone, e-mail if applicable): | Date: |

I, the undersigned, confirm that the information contained in this health form is correct and complete and that inaccurate or incomplete information could be harmful to the pupil’s health care and could result in early termination of the stay. I agree that the envelope containing this form can be disclosed to a doctor treating my child while abroad where medically necessary. If necessary, I agree to communicate all relevant information relating to the health of my child to the receiving school and the host family. All personal data will be treated as confidential.

|  |  |
| --- | --- |
| Pupil’s signature (if he/she is not a minor) | Date |
|  |  |
| Parent(s)’ signature | Date |
|  |  |