Chilliwack School District international student program

Student's Statement of Health

(To be completed by a licensed Physician.)

Student's Name: _____ Date of Birth: ____ ____ ____
Family Name(s) Given Name(s) *Day Month Year*

Address: _____

_____

Give your opinion of the general state of the applicant's physical, mental and emotional health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

If the applicant's health is only fair or poor, please explain: _____

_____

Does the applicant have a chronic disease which may affect his/her ability to benefit from or participate in the Chilliwack School District International Student Program? *(eg. Diabetes, heart disease, systic fibrosis, etc.)*

☐ Yes ☐ No If yes, please explain: _____

Does the applicant have a chronic neurological disorder which may affect his/her ablity to benefit from or particiate in the Chilliwack School District International Student Program? *(eg. Cerebral Palsy, Autism, Down's Syndrome, etc.)*

☐ Yes ☐ No If yes, please explain: _____

Does the applicant have any mental health issues which may affect his/her ability to benefit from or participate in the Chilliwack School District International Student Program?

☐ Yes ☐ No If yes, please explain: _____

Does the applicant have any cognitive learning issues which may affect his/her ability to benefit from or participate in the Chilliwack School District International Student Program?

☐ Yes ☐ No If yes, please explain: _____

Does the applicant have any physical or mobility issues which may affect his/her ability to benefit from or participate in the Chilliwack School District International Student Program?

☐ Yes ☐ No If yes, please explain: _____

Does the applicant have a visual or hearing impairment which may affect his/her ability to benefit from or participate in the Chilliwack School District International Student Program?

☐ Yes ☐ No If yes, please explain: _____

Are there any restrictions on the student's participation in school and/or school activities?

☐ Yes ☐ No If yes, please explain: _____

Physician's Name: _____

Physician's Address: _____

Physician's Signature: _____ Date: _____

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Student's Record of Immunization

(Please print clearly in English,)

Student's Name: _____ Date of Birth: _____ _____ _____

Family Name(s) *Given Name(s)* *Day* *Month* *Year*

Please indicate the dates student received the following immunizations:

	1st dose *yyyy/mm/dd*	2nd dose *yyyy/mm/dd*	3rd dose *yyyy/mm/dd*	4th dose *yyyy/mm/dd*	5th dose *yyyy/mm/dd*
Tetanus					
Diphtheria					
Pertussis *(Whooping Cough)*					
Polio					
Haemophilus Influenzae type B					
Measles *(Rubeola)*					
Mumps					
Rubella *(German Measles)*					
Hepatitis B					
Varicella *(Chickenpox)*					
Meningococcal C					
Pneumococcal					
Other:					

Physician Name: _____

Physician Signature: _____