EAST SIDE UNION HIGH SCHOOL DISTRICT
International Student Program
Health History & Release Form

This must be completed by a Medical Doctor (please print or type legibly)

Student's Name: _____ Country: _____

Home Address: _____
City **Postal Code**

Home Telephone: _____

Date of Birth: _____/_____/_____ Sex: Female / Male
Month / Day /Year

Height: _____ Weight: _____
To convert meters to feet multiply by 3.28 To convert kilos to pounds multiply by 2.205

	Yes	No		Yes	No
Allergies	☐	☐	Heart Blood Vessels	☐	☐
Appendicitis	☐	☐	Malaria	☐	☐
Has Appendix been removed?	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Rheumatic Fever	☐	☐
Cancer Tumors	☐	☐	Scarlet Fever	☐	☐
Convulsive Disorders	☐	☐	Smallpox	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐
Eating Disorders	☐	☐	Typhoid Fever	☐	☐
Epilepsy	☐	☐	Thyroid Disease	☐	☐
German Measles	☐	☐	Serious or Persistent Cough	☐	☐
Hepatitis	☐	☐	Serious or Persistent Headache	☐	☐
Hernia	☐	☐	Migraine	☐	☐
Been operated for hernia?	☐	☐	Ulcer	☐	☐
Other Abdominal Organs	☐	☐	Vertigo, Dizziness	☐	☐
Kidney Disease	☐	☐	Lungs, Respiratory System	☐	☐

Any disease, impairment, or abnormality of:

Eyes or Sight	☐	☐	Bones, Joints or Locomotor Sys.	☐	☐
Ears or Hearing	☐	☐	Brain or Nervous System	☐	☐
Tonsils, Nose or Throat	☐	☐	Blood or Endocrine System	☐	☐
Has his/her Tonsils been removed?	☐	☐	Other _____		
Stomach or Digestive System	☐	☐			
Genito-Urinary System	☐	☐			

Health History & Release Form

Please give detailed information (including dates) regarding any disease or impairment mentioned on the first page:

_____

_____

Has the applicant ever been hospitalized? Yes ☐ No ☐

If yes, please give date, diagnosis and description of illness or accident:

_____

Is the applicant currently taking any injections or medication? Yes ☐ No ☐

If yes, please give name(s) of medication(s), injection(s), and diagnosis:

_____

_____

Does the applicant have a history or present evidence or nervous, emotional, or mental abnormality, i.e. neurosis, nervous breakdown, nervous fatigue, recurrent nightmares, sleepwalking? _____

Is there any history of anorexia or bulimia? _____ Yes _____ No

If yes, please give details:

_____

_____

Does applicant have any health limitations and/or any pertinent medical information necessary for International Student Program if applicant is to be considered for placement abroad? _____ Yes _____ No

If yes, please comment fully: _____

Will the applicant need any orthodontic care during the coming year? _____ Yes _____ No

If yes, attach a statement from the Orthodontist, including patient's present status and date orthodontic care will be completed.

Has the applicant any history or present of any allergy?

_____ Applicant is allergic to what? (food, drug, pollen, animals, other)_____ Reaction to allergy (e.g., eczema, hives, hay fever, asthma, other)_____

Last know allergicreaction:_____

Will the applicant need to have medication while in the United States? _____

• Injected Medication (give names, dosages and dates): _____ _____

• Oral Medication (give names, dosages and dates): _____

Has the applicant had asthma? If so, give details and dates: _____

In your opinion, the general state of applicant's health is: Excellent ☐ ☐ Good ☐ Fair ☐ Poor

IMMUNIZATION RECORD FOR: _____
Student Name
Date of Birth: Month ____Day ____Year_____

Please record all dates with MONTH/DATE/YEAR: (Example: 8/ 23 / 99)

DTP Needs 4 ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ **Tdap** ___/___/___

POLIO ___/___/___ ___/___/___ ___/___/___ ___/___/___

MMR OR
MEASLES ___/___/___ ___/___/___ Date of Disease: ___/___/___
MUMPS ___/___/___ ___/___/___ Date of Disease: ___/___/___
RUBELLA ___/___/___ ___/___/___ Date of Disease: ___/___/___

HEPATITIS ___/___/___ ___/___/___ ___/___/___ (Needs three)

VARICELLA ___/___/___ ___/___/___ Date of Disease ___/___/___

MCV4 ___/___/___

Has student ever had a BGC? Yes ____ No ____ Date: ___/___/___

TB Test: date of test: _____ Result: Test was: ___ Negative (no TB) _____Positive

Has Student ever had a chest X-Ray? Result: _____ Date: ___/___/___

_____
Name of Physician OR Office Stamp (type or print)

_____
Signature of Physician

_____
Street Address

_____/_____ _____
Postal Zone City Date of Student Examination Month/Date/Year

Permission for Medical Care / Release Form

We/I give our/my permission for my son/daughter to receive the immunizations in the United States if deemed necessary (DTP, Polio, MMR, TB Test or Chest X-Ray). Also as the applicant's parent(s) or legal guardian(s), We/I agree to authorize East Side Union High School District or the Host Family to act for us/me in any emergency, accident, or illness during the period of time the student is involved in the East Side District International Student Program. This covers the period of time the student boards transportation scheduled by the International Student Program until the student leaves the program and returns to his/her home country as scheduled by East Side Union High School District.

We hereby certify that the information given in this Certificate of Health in complete and accurate.

Father or Legal Guardian Signature _____ **Date:**_____
Month /Day/Year

Mother or Legal Guardian Signature _____ **Date:**_____
Month /Day/Year

PARENTS' GUIDE TO IMMUNIZATIONS

REQUIRED FOR SCHOOL ENTRY

Starting July 1, 2019

Students Admitted at TK/K-12 Need:

- **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap, or Td) — 5 doses**
  (4 doses OK if one was given on or after 4th birthday.
  3 doses OK if one was given on or after 7th birthday.)
  For 7th-12th graders, at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday.
- **Polio (OPV or IPV) — 4 doses**
  (3 doses OK if one was given on or after 4th birthday)
- **Hepatitis B — 3 doses**
  (Not required for 7th grade entry)
- **Measles, Mumps, and Rubella (MMR) — 2 doses**
  (Both given on or after 1st birthday)
- **Varicella (Chickenpox) — 2 doses**

These immunization requirements apply to new admissions and transfers for all grades, including transitional kindergarten.

Students Starting 7th Grade Need:

- **Tetanus, Diphtheria, Pertussis (Tdap) —1 dose**
  (Whooping cough booster usually given at 11 years and up)
- **Varicella (Chickenpox) — 2 doses**
  (Usually given at ages 12 months and 4-6 years)

In addition, the TK/K-12 immunization requirements apply to 7th graders who:

- previously had a valid personal beliefs exemption filed before 2016 upon entry between TK/Kindergarten and 6th grade
- are new admissions

Records:

California schools are required to check immunization records for all new student admissions at TK/Kindergarten through 12th grade and all students advancing to 7th grade before entry. Parents must show their child's Immunization Record as proof of immunization.

IMM-222 School (1/19) California Department of Public Health • Immunization Branch • ShotsForSchool.org

EAST SIDE UNION HIGH SCHOOL DISTRICT
International Student Program
Permission for Medical / Emergency treatment
HIPAA / Host Family Agreement FORM

Applicant's Name: **Date of Birth:** **(month/day/year)**

CONSENT FOR MEDICAL TREATMENT: This form authorizes the East Side Union High School District to obtain medical care for your student in your absence. This consent form is intended to prevent a potential delay in providing necessary medical services for your student. Every effort will be made to contact the parent or guardian before any major medical treatment is administered to your student.

We hereby authorize East Side Union High School District representatives, their officers, and/or agents, to obtain any and all medical treatment deemed necessary, including the administration of an anesthetic and surgery, for:

Student's Name: _____ D.O.B: _____
(month/day /year)

Please note, this form must be signed as is; no changes to the form will be accepted.

_____ Date:_____

Parent/Guardian Signature:

Health Insurance Portability and Accountability Act (HIPAA)

I (Name of Student), _____, hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me on my behalf, to release the following health information:

- **All information in my medical records, including my medical history, and results of medical examinations and lab tests.**
- **All financial and claim information related to my medical bills.**

To: Representatives of the East Side Union High School District, 830 N. Capitol Avenue, San Jose, CA 95133
For the following purpose: To obtain medical treatment.
This authorization shall remain in effect for two years from the date of my signature.
I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be

affected if I do not sign this authorization.

- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Student Signature: _____ Date: _____

Student Name (Print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Print): _____ Date: _____

Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law from further disclosure. Please contact your physician or provider of service for your medical information.

Student Signature:_____ **Date**:_____

Student Name (print):_____

Parent/Guardian Signature: _____ **Date**:_____

Parent/Guardian Name (print):_____