

**Shiloh Christian School, 1915 Shiloh Drive, Bismarck, North Dakota, 58503, USA**  
**Contact: Todd Benson, 701-221-2104, [todd.benson@shilohchristian.org](mailto:todd.benson@shilohchristian.org)**  
**School Website: <https://shilohchristian.org/>**

**Certificate of Health for International Student**

Dear Physician or Licensed Medical Practitioner:

Date of Examination \_\_\_\_\_

This applicant is applying to become an international student for an academic year or semester in the United States. Please fully complete this form indicating any illness or current/potential health problem(s) that we should be aware of in considering this applicant for participation in a term abroad as an international student.

Applicant's Full Legal Name \_\_\_\_\_  
(first) (middle) (last)

Home Street Address \_\_\_\_\_ Country \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip Code \_\_\_\_\_ Birth Date (month/day/year) \_\_\_\_\_

Has the applicant had the following illnesses/conditions?

	Yes	No		Yes	No
Allergies			Mumps		
Appendicitis			Parasites		
Has appendix been removed?			Pneumonia		
Asthma			Polio		
Chicken Pox			Rheumatic Fever		
Diabetes			Rubella		
Drug or Alcohol Abuse			Scarlet Fever		
Enuresis			Serious or Persistent Cough		
Epilepsy			Serious or Persistent Headaches		
Hepatitis			Smallpox		
Hernia			Tuberculosis		
Operated on for hernia?			Typhoid		
Successfully?			Vertigo, Dizziness		
Malaria			Significant Other Contagious Diseases (not		
Measles (Rubeola)			mentioned above)		

Has the applicant had any disease, impairment or abnormality with the following?

	Yes	No		Yes	No
Blood or Endocrine System			Lungs, Respiratory System		
Bones, Joints or Locomotor System			Other Abdominal Organs		
Brain or Nervous System			Personality or Behavior		
Ears or Hearing			Skin (Acne, etc.)		
Eating Disorder			Stomach or Digestive System		
Eyes or Sight			Tonsils, Nose or Throat		
Genito-Urinary System			Have tonsils been removed?		
Heart or Blood Vessels					

Please give full information (including dates and details) about every disease or impairment mentioned ("yes" response) for any of the above questions.

\_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse Rate: \_\_\_\_\_ Is pulse rhythm normal? \_\_\_\_\_

Blood Pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_ Are pupillary and knee reflexes normal? \_\_\_\_\_

What is the applicant's vision: Without eyeglasses; OD \_\_\_\_\_ OS \_\_\_\_\_

With eyeglasses; OD \_\_\_\_\_ OS \_\_\_\_\_

If allergic to anything, how severe is the allergy and how is the allergic reaction treated/controlled? \_\_\_\_\_

Has the applicant ever been hospitalized? \_\_\_Yes \_\_\_No If yes, please give date, diagnosis and outcome of each illness or accident.

Has the applicant ever consulted a neurologist, psychiatrist, psychologist, or any other specialist in nervous or psychological disorder?

\_\_\_Yes \_\_\_No If yes, please explain \_\_\_\_\_

Does the applicant have any health limitations or do you know of any pertinent medical information which is important for the Shiloh Christian School organization to know which would limit the student's participation in normal school, family, sports and community life? \_\_\_Yes \_\_\_No If yes, please comment fully \_\_\_\_\_

Is the applicant currently getting any injections or taking any medication? \_\_\_Yes \_\_\_No If yes, please give name(s) of medication(s) and injections and diagnosis \_\_\_\_\_

Orthodontic care is not covered by Shiloh Christian School's medical insurance policy.

**History of Immunizations/Vaccinations**

Vaccine/Test	1-Mon./Day/Year	2-Mon./Day/Year	3-Mon./Day/Year	4-Mon./Day/Year	5-Mon./Day/Year
Diphtheria					
Polio-vaccine type					
Tetanus/Toxoids (Td)					
Pertussis					
Mumps					
Rubella					
Measles (Rubeola)					
Hepatitis B					
Tuberculosis (Mantoux Test) or BCG Test					
Smallpox (optional)					
Chicken Pox					

**Other Immunizations/Vaccinations**

Vaccine	1-Mon./Day/Year	2-Mon./Day/Year	3-Mon./Day/Year	4-Mon./Day/Year	5-Mon./Day/Year
Typhoid					
Cholera					
Yellow Fever					
Other					
Other					

Recommended for general physical activity in school:

Full physical activity including physical education classes (including sports activities).

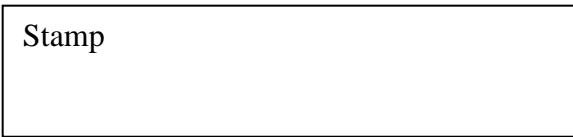
Modified physical activity because of \_\_\_\_\_

If the student is eligible and wishes to participate in the school's competitive sports program, is there any factor in the student's physical condition which might pose a problem to him/her?  Yes  No If yes, please explain \_\_\_\_\_

**For Physician:**

In my opinion the general state of applicant's health is: (check one)

Excellent  Good  Fair  Poor



Comments: \_\_\_\_\_

I hereby certify, to the best of my knowledge, the above information is true and correct:

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_ Country of license \_\_\_\_\_

Name of Physician \_\_\_\_\_

Address \_\_\_\_\_

**For Parent(s):**

We, the parent(s), consent and authorize Shiloh Christian School or any adult host family member to obtain any medical, dental, surgical, psychological, psychiatric, or hospital care, deemed necessary by any health care provider, for the health, treatment and care of this exchange student applicant during applicant's participation in Shiloh Christian School's program. All current and prior significant physical and mental health conditions have been fully disclosed above. We further understand that we are obligated to inform Shiloh Christian School of any significant changes to the applicant's health conditions that may occur after the signature of this document. The parent(s) authorize the health care provider to release all health care records relating to the applicant to Shiloh Christian School.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_