Shiloh Christian School, 1915 Shiloh Drive, Bismarck, North Dakota, 58503, USA
Contact: Todd Benson, 701-221-2104, 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**
Diptheria					
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:

Stamp

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 _____