Fairhall School

CERTIFICATE OF HEALTH
(Please Print)

To be completed and signed by the applicant's physician.
The physician should not be related to the candidate

Name: _____
Last First Middle

Address: _____

_____

Date of Birth: _____/_____/_____
Date Month Year

Has the participant had the following illnesses/conditions?

YES	NO	
		Allergies
		Appendicitis
		Has appendix been removed?
		Asthma
		Chicken Pox
		Diabetes
		Drug or Alcohol Abuse
		Epilepsy
		Hepatitis A or B or C
		Hernia
		Operated on for hernia?
		Successfully?
		Malaria
		Mumps

YES	NO	
		Parasites (Intestinal)
		Pneumonia
		Polio
		Rheumatic Fever
		Rubella
		Scarlet Fever
		Serious or persistent cough
		Serious or persistent headaches
		Tuberculosis
		Typhoid
		HIV/Aids status
		Significant other contagious diseases not mentioned above.

_____

Any disease, impairment, abnormality

		Blood or endocrine system
		Bones, joints
		Brain or nervous system
		Ears or hearing
		Eyes or sight
		Genito-urinary system

		Heart or blood vessels
		Lungs, respiratory system
		Other abdominal organs
		Skin (Acne etc)
		Stomach or Digestive System
		Tonsils, nose or throat
		Have tonsils been removed?

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

_____

_____

_____

Describe in detail any medication currently taken, or treatment received, during past years:

_____

_____

_____

If allergic, how severe is the allergy and how is the allergic reaction treated/controlled?

_____

_____

What was the date of the student's last dental check up? _____

Does the student wear dental braces? Yes ☐ No ☐

Will the participant need any orthodontic care during the coming year ☐ Yes No. ☐ If yes, attach a statement from the orthodontist, indicating present status, exact care essential to the orthodonture and date care will be completed. (Orthodontic work is NOT covered under Unicare Medical Insurance).

History of Immunizations/Vaccinations

Please indicate month and year of all Immunizations/Vaccinations (include "boosters") received by participant, the most recent of which must have occurred within the past 10 years.

Vaccine/Test	Date (mo/yr)	Date (mo/yr)	Date (mo/yr)	Date (mo/yr)	Date (mo/yr)
Diphtheria	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Polio - Vaccine Type	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Tetanus/Toxoids (Td)	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Pertussis	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Mumps	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Rubella	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Measles (Rubeola)	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Tuberculosis (Mantoux Test) or BCG Test	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Hepatitis A	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Hepatitis B	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5

2. **Other Immunizations/Vaccinations**

If participant has had any of the following, please indicate the month and year given (Immunizations/ Vaccinations below are not required by most Host Country Schools).

Vaccine	Date (mo/yr)	Date (mo/yr)	Date (mo/yr)	Date (mo/yr)	Date (mo/yr)
Typhoid	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Cholera	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Yellow Fever	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Other	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Other	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5

For Physician:

In my opinion the general state of participant's health is : (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments: _____

_____

_____

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

_____ Signature of Physician

_____ Date of Examination

_____ Name of Physician (Please Print)

STAMP

_____ Address

_____

_____ Country of License to practice medicine

For the Parents/Legal Guardians

We, the Parent(s) /Legal Guardian(s), consent and authorize Fairhall 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 student during the student's enrolment at Fairhall School. The Parent(s) / Legal Guardian(s) authorize the health care provider to release all health care records relating to the student to Fairhall School. We also accept full responsibility for any medical expenses for our son/daughter, which is not covered by his/her insurance policy.

_____	_____
Signature of Parent or Legal Guardian	Signature of Parent or Legal Guardian
_____	_____
Date	Date

Please check the New Zealand Immigration Website (http://www.immigration.govt.nz) to check the acceptable standard of health requirements regarding the submission of Medical and chest x-ray certificate when applying for a student visa. The above medical check is for school purposes i.e. to assist us in supporting this student in terms of her health, treatment and care of during his/her enrolment at Fairhall School.