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Name of  
Participant:

Sending National  
Association:

## GENERAL INSTRUCTIONS:

**Thank you for taking the time to complete this form fully. The information it contains will help CISV to plan for your welfare and will assist any medical practitioners in the event that you should require their care during travel or the programme. This form will be shared with programme staff, leaders and host families.**

- Completing this form is a condition of participation in CISV international programmes
- Please complete this form in English either by typing or by hand, using black or blue ink and in capital letters.
- This form must be **completed and signed not more than 3 months before participation** in the CISV International programme. You must notify CISV of any relevant changes to the information that may occur prior to the programme.
- The information in this form is confidential and must be stored securely.
- The only official text for this form is the English Edition.
- Please take the signed original of this form plus any supporting documents and one copy to the programme, and leave one copy with the sending Chapter.
- At the end of the programme, the original and all copies should be returned to either the adult participant or child participant travelling alone. In the case of a delegation, the original and all copies should be given to the Leader, who should then return them to the child's parent/guardian on arrival.
- Parts A, B, C, D and E are to be filled out by the adult (aged 18+) participant or by the parent/legal guardian of the child participant (up to and including age 17). It is also required that participants aged 16 and 17 review the form and sign it in Section E.
- **If there are any special needs or allergies in Part B or medical, mental, emotional or social health concerns included in this form that CISV would need to know about to provide appropriate care, then please send that information to the programme staff in advance of the programme.**
- Make sure to take the filled out parts A, B, C, D and E with you to the doctor (physician), when going for the health check.
- Part F is the only part that must be completed by a doctor who meets with and conducts an appropriate health check on the participant.

For information about how CISV uses the personal data you provide in this form, please read our Privacy Notice on [www.cisv.org](http://www.cisv.org). By providing your personal data to CISV, you agree to the terms of the Privacy Notice.

**PART A: PARTICIPANT INFORMATION**

TO THE PARTICIPANT / PARENT / GUARDIAN: Please complete this form and review it with your physician during your consult.

<b>Participant's Name:</b>			
	<i>Last</i>	<i>First/Given</i>	<i>Middle</i>
Biological Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (e.g. Intersex)	Date of Birth: ____ - ____ - ____ <i>dd mm yyyy</i>	Country of Citizenship:	
Participant will attend CISV programme in (Host Nation):		Duration of programme (start date and end date): Start date:                      End date:	
<b>In case of emergency, please contact (Name and Relationship):</b>		Language(s) spoken:	
Contact number (Home):  -                      - <i>country code                      area code                      number</i>		Contact number (Office and/or Mobile):  -                      - <i>country code                      area code                      number</i>	

## PART B: CURRENT MEDICATIONS AND NEEDS

Name of Participant:

Sending National Association:

### Diet

Do you require a special diet?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please give details:	
Are there any foods that you cannot or should not eat?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please give details:	

### Allergies

#### Do you have allergies to:

Food	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, please specify:</i>
Bee stings or insect bites	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, please specify:</i>
Medicines	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, please specify:</i>
Others	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, please specify:</i>
Do you have to carry an anaphylaxis-set with you?*	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, please specify contents:</i>

What medications can you be given for an allergic reaction?

**\*If you need one, please remember to bring your anaphylaxis-set with you.**

**Medications or other remedies:** This is any substance a person takes to maintain and/or improve his/her health and includes prescription medicine, over the counter medication, vitamins, homeopathic remedies, etc.

**Do you take any medications?\*** Please include non-prescription medications or remedies to avoid any misunderstanding.

Brand Name	Generic Name	Reason for taking it	Dose, Schedule, Special Instructions

**\*Please ensure sufficient supply for the trip's duration.**

**Please bring any specific medical documentation (e.g. pathological findings in an electrocardiogram or x-ray) that would be helpful for a doctor in the host country to have, should you require treatment. Bringing it with you can help avoid unnecessary and expensive procedures. It is recommended that you discuss this with your regular physician.**

**PART C: HEALTH HISTORY**

Name of Participant:

Sending National Association:

**In case of hospitalization, participant’s medical records are available from:**

Physician / Hospital:	
Telephone Number:	
Address:	

**Has the participant ever had any infectious diseases? Please tick  any that apply:**

<input type="checkbox"/> Measles (Rubeola)	<input type="checkbox"/> Whooping cough (Pertussis)	<input type="checkbox"/> Hepatitis (specify)	<input type="checkbox"/> Frequent tonsillitis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet fever (Scarlatina)	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Rubella (German measles)	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Yellow fever	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Chickenpox (Varicella)	<input type="checkbox"/> Otitis	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pneumococcal infection
<input type="checkbox"/> Staphylococcal infection	<input type="checkbox"/> Streptococcal infection	<input type="checkbox"/> Other, please specify:	

**Please provide a brief history/explanation regarding above and whether they have left any lasting complications that CISV should be aware of:**

**Does the participant have any recurring medical problems or chronic conditions? Please tick  any that apply:**

<input type="checkbox"/> Anaemia/blood disorder	<input type="checkbox"/> Heart disease	<input type="checkbox"/> HIV	<input type="checkbox"/> Migraines/headaches
<input type="checkbox"/> Asthma	<input type="checkbox"/> Endocrine disorder	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Mobility limitations
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Musculoskeletal problems
<input type="checkbox"/> Autoimmune disorder	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Neurological concerns
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Eye disease*	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Gastrointestinal disease	<input type="checkbox"/> Sleep disorder	
<input type="checkbox"/> Other, please specify:			

**\*If you wear glasses or contact lenses, please bring a copy of your prescription to the programme.**

Please specify if there is anything that the programme staff should be aware of relating to any of the above:

Name of Participant:

Sending National Association:

**Is there any family history of the following? Please tick :**

Allergies or asthma

Epilepsy

Hypertension

Migraines/headaches

Diabetes

Heart disease

Mental health concerns

Skin diseases

Other, please specify:

Please specify if there is anything that the programme staff should be aware of relating to any of the above:

**In the past 5 years, has the participant ever been a hospital patient for any other condition? Yes  No**

<i>Date</i>	<i>Diagnosis</i>	<i>Details</i>

**If applicable:**

Has the participant started menstruating?

Yes  No

If yes, is there any menstrual disorder?

Yes  No

What medication can be given for menstrual pain/dysmenorrhea?

Is the participant pregnant or is there a possibility that they may be pregnant?

Yes  No

**Immunizations:**

Please provide information on immunizations received – those in **bold** are required for participation in any CISV International programme unless there is a documented medical exemption (see our Programme Basic Rules – InfoFile C-03):

<i>Immunization</i>	Yes	No	Date of inoculation or most recent booster	<i>Immunization</i>	Yes	No	Date of inoculation or most recent booster
<b>DPT (Diphtheria, Pertussis, Tetanus)</b>	<input type="checkbox"/>	<input type="checkbox"/>		MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Polio</b>	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Measles</b>	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Rubella</b>	<input type="checkbox"/>	<input type="checkbox"/>		Influenza	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal	<input type="checkbox"/>	<input type="checkbox"/>		Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>		Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>		Other, please specify:			

**Has the participant received all the necessary immunizations for travel to the host nation? Yes  No**

Please give details below:

Immunization	Yes	No	Date
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

## PART D: MENTAL, EMOTIONAL AND SOCIAL HEALTH

Name of  
Participant:

Sending National  
Association:

**Has the participant ever been diagnosed with a condition that impacts learning (e.g. ADHD, sensory processing problem)** Yes  No  **If yes, please specify:** \_\_\_\_\_

**Does the participant have a psychiatric diagnosis such as depression, Obsessive-Compulsive Disorder, panic/anxiety disorder, self-harming behaviours or suicidal thoughts etc.?** Yes  No  **If yes, please specify:**  
\_\_\_\_\_

**Does the participant have any emotional/mental health concern (whether professionally diagnosed or not) that could impact the CISV programme or their participation in CISV in any way? (Specify: \_\_\_\_\_)** Yes  No

**During the past year has the participant seen a professional (e.g. doctor, psychologist, psychiatrist) to address mental, emotional or social health concerns that could impact the CISV programme or their participation in CISV in any way?** Yes  No  **If yes, please specify:** \_\_\_\_\_

If “yes” was the answer to any of the four statements above, please attach documentation that addresses the following:

- describes the concern and the management plan (including medication) while in our programme;
- describes the behaviours that will indicate to our staff that the participant needs professional referral; and
- provides recommendations for how to help the participant and lists any special needs.

**The participant has had a traumatic life event (e.g. the loss of a family member) that continues to affect the participant’s life in a way that could impact the CISV programme or their participation in CISV in any way? Yes  No**

If “yes”, please attach written information about the event, its impact on the participant’s life, and care tips for the staff at the programme.

**Have we forgotten to ask something?** Please use the box below to provide additional information about the participant’s health or needs, including any pre-existing conditions that you have not declared earlier in this form. We are particularly interested in information that has an impact on the participant’s ability to fully participate in our programme. Attach additional information if needed.

Name of  
Participant:

Sending National  
Association:

## PART E: CERTIFICATION

I certify that all responses made on this form are true, accurate and complete, and I will notify CISV International of any relevant changes that may occur prior to or during my international programme.

I have included in this form, (and I will advise my CISV Chapter, my delegation Leader and the programme host Staff) of any special needs or assistance that I/the participant may have relating to my/the participant's physical and mental health. I am aware that if I do not provide complete information, this may cause hardship and concern to others and may affect my/the participant's own welfare. I understand that if I do not provide complete information, CISV may decide to send me/the participant home from the programme at my/the participant's own expense.

I consent to the release of medical information to CISV International or its agents so that they may provide me with needed assistance. I further agree that CISV International or its agents may release information to other persons who may need this information to assist me/the participant or to assist others in the programme. I understand and agree that this form may be released to the host Chapter or Programme Director for such purposes.

Signature of Participant/Junior Counsellor (age 18+) / Adult Leader or Staff:

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian of Participant/Junior Counsellor under age 18:

\_\_\_\_\_ Date: \_\_\_\_\_

## Part F: PHYSICIAN'S DECLARATION CONCERNING CISV PARTICIPANT

**TO THE PHYSICIAN:** The participant will take part in a CISV International programme. Please consider the participant's general physical fitness and mental health in relation to the general requirements of programme participation as will be explained to you by the participant or his/her parent/guardian. Please review the health information entered in Parts A, B, C and D of this form and any other information you have available to you regarding the participant's medical history. This may include a physical examination if considered appropriate. Please discuss with the participant any medical advice and vaccinations necessary for travel to the host country. **The signing physician is responsible only for information entered in Part F of this form.**

<input type="checkbox"/> I am <input type="checkbox"/> I am not	the participant's primary care physician.	Name of participant: _____ Country: _____
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<b>I have reviewed the information provided above and verify it is consistent with the information available to me about the participant's medical history and my current professional assessment of their health status:</b>	<input type="checkbox"/>
<b>I confirm that I am not aware of any prescribed medication or mental or physical health concerns or diagnoses for this patient that are not accurately listed in Parts A, B, C, D and E of this form:</b>	<input type="checkbox"/>
<b>I have no information on, or knowledge of, the participant's medical history that could be relevant to the participant's participation in the CISV programme beyond what the participant has shown me in the above sections of this form</b>	True <input type="checkbox"/> False <input type="checkbox"/> (please provide further information below)

Comments:

<b>The participant appears to be physically and mentally fit for travel to and participation in the CISV International programme:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Physical examination performed:	Yes <input type="checkbox"/> No <input type="checkbox"/>

Additional comments/relevant examination findings:

Is there any apparent evidence of alcohol and/or drug abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Is there any apparent evidence of infectious disorders or diseases?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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<b>This participant may take part in all activities with the following <i>restrictions or recommendations</i>:</b>	None <input type="checkbox"/>
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Details on limitation of participation (if any):



**TRAVEL MEDICINE**

The participant has received appropriate advice on travel health relevant to travel to the host nation:

Yes  No

The participant has received all recommended immunizations for travel to the host nation:

Yes  No

The participant is receiving malaria prophylaxis for travel to the host nation (if necessary):

Yes  No

I certify that all information entered on this page of this form is true and accurate to the best of my professional knowledge.

Signature of Examining Physician: \_\_\_\_\_

Name of Examining Physician: \_\_\_\_\_

Contact details of Examining Physician: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Stamp or Business Card here [Optional]:
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