



NB: This information is confidential. It will be destroyed as provided by law. The only official text for this form is this English edition.

**CISV Health Form – HF 2000 continued** Page 2 of 2. ☺ Completed forms are not to be transmitted by E-mail

**Carry this form with the relevant CISV Legal / Insurance Form – TWAL 2000, ALIF 2000 or YLIF 2000.**

Parent / Adult Participant, please complete in English. For international use, please complete and carry official English language forms.

Participant's name:  Country:

**Medical History:** Apart from minor childhood illnesses, is the participant's health generally good? Yes  No

Yes No Year  
Year Booster

**Infection History**

**Immunization History:**

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubeola)
<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Rubella
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox (Varicella)
<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough (Pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever (Scarlatina)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Otitis (inflammation of the ear)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (specify)
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Fever
<input type="checkbox"/>	<input type="checkbox"/>	Malaria
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal Infections
<input type="checkbox"/>	<input type="checkbox"/>	Streptococcal Infections
<input type="checkbox"/>	<input type="checkbox"/>	Staphylococcal Infections
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)
<b>Chest X-ray Result</b>		

Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox (Varicella)	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus Toxoid	<input type="checkbox"/>	<input type="checkbox"/>	
HNIg (human normal immunoglobulin)	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis (specify Hib <input type="checkbox"/> or C <input type="checkbox"/> )	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Malaria Prevention (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Encephalitis (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculin (BCG)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Alternative / additional TB test information (if any):</b>			
<b>TB Test</b> (tick ✓ below)	<b>Test Date</b>	<b>Result</b>	
Mantoux / PPD <input type="checkbox"/> or Heaf / Tine <input type="checkbox"/>			

**Yes No Year Hospitalization History**

- Diseases / injuries requiring X-ray examination (specify):
- Illnesses requiring hospitalization (specify):
- Injuries requiring hospitalization (specify):

**Yes No Chronic Conditions & Recurring Medical Problems**

- 01.** Drug reactions (specify drug & reaction, give details)
- 02.** Other allergic reactions (food, animal, plant, give details)
- 03.** Asthma or other lung / respiratory disorder (give details)
- 04.** Enuresis (bed wetting)
- 05.** Endocrinal disorder: Diabetes  Thyroid  (give details)
- 06.** Epilepsy
- 07.** Gynaecological / Menstrual disorder
- 08.** Kidney / stomach disorder (give details)
- 09.** Heart / blood pressure disorder (give details)
- 10.** Ear / nose / throat disorder (give details)
- 11.** Frequent Diarrhoea or Dysentery
- 12.** Sleep disorder
- 13.** Other disorders (give details)
- 14.** Emotional / behavioural counselling (give details)
- 15.** Wears braces or has "caps" / artificial teeth
- 16.** Glasses / contact lenses (**carry copy of prescription**)
- 17.** Physical limitations (give details)
- 18.** Special diet (give details)

**Details** (re past / chronic / recurring conditions)

**Signature:**

of Participant's Parent / Adult Delegate / Staff (as relevant)

**Date:**

/ /  
dd mm yyyy

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