



EF ACADEMY

EF Academy Pasadena Health Certificate

To Parents and the examining Doctor/Provider (includes MD, PA, & NP)

Important: This form must be fully filled out. All questions must be completed. The doctor completing this form must be familiar with the student's entire medical/mental health history and should consult fully with the parent/guardian of the student to ensure that the form is as complete and accurate as possible. The examining physician cannot be a parent or relative of the student. You may attach extra pages or documents if required..

Baseline Information

Family Name: _____ First Name(s): _____

Date of Birth (mm/dd/yyyy): _____ Gender: _____ Height: _____ Weight: _____

Blood group: _____ Blood pressure (Systolic/Diastolic): _____ Pulse rate: _____

Medical History

1. Are reflexes normal? Pupil: Yes No Knee: Yes No Other: _____

2. Is vision normal? Yes No Student uses glasses Student uses lenses

3. Does the student have any dietary restrictions? Please tick the following:

Halal Kosher Vegan Vegetarian Gluten Free Lactose Free Nut Allergic

If yes, please specify what type of nut(s) allergy: _____

4. Does this student have any allergies to food, medication, environmental substances, etc? Yes No

If yes, please indicate what is their reaction and how it must be treated (Allergies/Reaction/Required Treatment):

5. Does the student carry an epi-pen/epinephrine? Yes No

Medical Condition(s)

6. Has the student ever suffered from any of the following physical or medical conditions?

Indicate by checking the box in the appropriate column for "Yes" or "No":

Table with 6 columns: Condition, Yes, No, Condition, Yes, No, Condition, Yes, No. Rows include Asthma, Appendicitis, Diabetes, Epilepsy, Hepatitis, Hernia, Pneumonia, Psoriasis, Rheumatic Fever, Scarlet Fever, Serious or Persistent Cough, Serious Persistent Headache, Tuberculosis, Typhoid Fever, Vertigo or Dizziness, Any disease, impairment, or abnormality of: Eyesight, Ears or Hearing, Dental Condition, Tonsils, nose, or throat, Tonsils removed, Stomach or digestive system, Genito-urinary system, Heart or Blood vessels, Abdominal organs, Skin (acne, etc), Lungs, respiratory system, Bones, joints, or locomotor system, Scoliosis, Brain or Nervous System, Blood or Endocrine System.

If yes to any of the following above, please give a detailed explanation: _____

7. Based on my evaluation, the student is:

Medically eligible for all sports without restriction Medically eligible for certain sports: _____

Not medically eligible for any sports Not medically eligible pending further evaluation

Medically eligible for all sports without restriction with recommendations for further evaluation/treatment of: _____

Please give a detailed explanation as need for Question 7: _____

8. Is the student currently or have they ever experienced any of the following:

	Yes	No		Yes	No
Health Condition or injury other than routine illness (i.e., flu)	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization for any reason	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the following above, please give a **detailed** explanation: _____

9. Will the student be required or encouraged to seek any type of medical attention, treatment, or check-ups while at school? If yes, please give a **detailed** explanation: Yes No

10. Will the student be required or encouraged to take any type of prescription or non-prescription drugs, vitamins, or supplements? Yes No
If yes, please **specify and complete the mandatory Authorization for the School to Administer Medications (page 4)**:

Student Wellbeing

11. Has this student to your, their or their parent’s knowledge, ever experienced any of the following?

	Yes	No		Yes	No
Eating disorder (anorexia, bulimia, etc)	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>
Significant weight loss or weight gain for any reason	<input type="checkbox"/>	<input type="checkbox"/>	Emotional, physical, or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>
Constant worry, anxiety, high stress, depression, or sadness	<input type="checkbox"/>	<input type="checkbox"/>	Cutting or self-harming (or thoughts of doing this, including restricted eating, excessive exercising, purging, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Bullying or other social/family adjustment issues	<input type="checkbox"/>	<input type="checkbox"/>			
Learning disability or condition (ADD/ADHD, Dyslexia, etc)	<input type="checkbox"/>	<input type="checkbox"/>			

If “yes” to any of the above, please give a **detailed** explanation: _____

12. Has this student ever talked to a professional or another trusted adult (teacher, counselor, doctor, therapist, pastor, etc) about any of the above or other issues? Yes No

If “yes”, please give a **detailed** explanation: _____

13. Has this student ever been assessed by an educational psychologist or other medical person with regards to additional learning needs or support for school work? Yes No

If “yes”, please give a **detailed** explanation: _____

14. Has the student ever been diagnosed with one or more of the following conditions?

	Yes	No		Yes	No
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>
Dyscalculia	<input type="checkbox"/>	<input type="checkbox"/>	Specific Learning Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

If “yes” to any of the above, please give a **detailed** explanation: _____

15. Has the student ever been prescribed or taken any psychiatric drugs? Yes No If

“yes”, please **list** them, when they were prescribed, and if they are still taking it: _____

16. Does the student have any other health limitations, any pertinent medical information or, communicable disease that is important for EF Academy to know about? Yes No

If “yes”, please list them, when they were prescribed, and if they are still taking it: _____

Inoculations

Please complete all sections! All students traveling to the state of California are required to get all vaccines listed below prior to departure. Without the inoculations a student cannot legally register in a U.S. high school. It is important to write **month/day/ year**. If a student arrives without complete inoculations, the student’s parents or legal guardian are responsible for all costs incurred.

Without the complete inoculations, student cannot attend classes.

Important: (SB) 277, Effective January 1st, 2016, states that any Parents or guardians of students in any school or child-care facility, whether public or private, will no longer be allowed to submit a personal beliefs exemption to a currently required vaccine in the State of California.

Vaccine	Please write Doses Received as Month/Day/Year (mm/dd/yy)					Notes for School Requirements
	1st dose	2nd dose	3rd dose	4th dose	5th dose	
DTap (Diphtheria, Tetanus, Pertussis)						5 doses meet TK/K-12 requirement, as do: – 4 doses: if 1 dose given at age 4 years or older; – 3 doses, if 1 Tdap dose at age 7 years or older; – Tdap dose may meet 7th Grade requirement.
Oral/Inactivated Polio						4 doses meet TK/K-12 requirement, as do: – 3 doses, if 1 dose given at age 4 years or older
Hepatitis B						3 doses meet TK/K-12 requirement.
Tdap (Booster shot for Tdap)						1 dose given at age 7 years or older meets requirement for 7th grade advancement and 7th–12th grade admission.

Vaccine	Please write Doses Received as Month/Day/Year (mm/dd/yy)			Date of Disease (mm/dd/yy)	Notes for School Requirements
	1st dose	2nd dose			
Measles					2 doses must meet TK/K-12 requirement unless disease documented. Doses MUST be given at age 1 year or older.
Mumps					2 doses must meet TK/K-12 requirement unless disease documented. Doses MUST be given at age 1 year or older.
Rubella					2 doses must meet TK/K-12 requirement unless disease documented. Doses MUST be given at age 1 year or older.
Varicella/Chickenpox					2 doses must meet TK/K-12 requirement unless disease documented
Meningococcal					It is not mandatory for high school students in California to receive the meningococcal vaccine. However, we STRONGLY RECOMMEND that students getting the vaccine to prevent from contracting meningococcal. If you decide to opt out from the Meningococcal inoculation, please sign here with the understanding of the risk of meningococcal: _____ (parent/guardian)

17. Has the student ever been diagnosed with tuberculosis (TB)? Yes No

18. Has the student ever received a BCG inoculation? Yes No If yes, please state the date: _____

19. Mandatory TB Test for **NEW STUDENTS** (one of the following tests in the table below should be administered within 1 year of expected school start date, or an additional test may be required for students who have been to a high risk tuberculosis geographic area):

Skin Test (only accepted for students with NO prior BCG inoculation)	Blood Test	Note to Physician
Date: _____(mm/dd/yyyy) Result: _____	Date: _____(mm/dd/yyyy) Result: _____	If either test is positive, a Chest X-Ray must be administered. Did the chest x-ray indicate that the student has active or contagious TB? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please attach copy of TB skin and/or blood results to the Health Certificate .		Please attach X-Ray results to the Health Certificate .

19. Has the student ever tested positive for Covid-19 before? Yes No

If 'yes', please state the date and explain the severity of the case: _____

20. In my opinion, the general state of student’s health is: Excellent Good Fair Poor

21. Please note that students must be able to operate independently at EF Academy Boarding Schools in the US. Based on the status of the student’s physical and mental health, may this student travel to and study at an independent boarding school in the US? Yes No



Authorization for the School to Administer Medications

A. Authorization for the School to Administer Over-the-Counter (“OTC”) Medications

I give permission for the student to receive the following non-prescription medications if the EF Academy medical staff deems it necessary and appropriate. Dosage amounts and frequency will be determined according to the directions on the bottle unless otherwise directed by a physician:

	Yes	No		Yes	No
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic cream (e.g. Bacitracin)	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone cream	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine (e.g. Claritin)	<input type="checkbox"/>	<input type="checkbox"/>	Allergy (e.g. Claritin, Zyrtec)	<input type="checkbox"/>	<input type="checkbox"/>
Antacid (e.g. Tums)	<input type="checkbox"/>	<input type="checkbox"/>	Oral Product containing Benzocaine (e.g. Oragel)	<input type="checkbox"/>	<input type="checkbox"/>
Cold Medications (e.g. Guaifenesin, Phenylephrine)	<input type="checkbox"/>	<input type="checkbox"/>	Anti-nausea products (e.g. Emetrol)	<input type="checkbox"/>	<input type="checkbox"/>
Anti-diarrheal (e.g. Immodium)	<input type="checkbox"/>	<input type="checkbox"/>			

Parents/Guardians may also provide permission for the School to administer common OTC medicines such as OTC pain medication (e.g. Ibuprofen or Tylenol), allergy medications (e.g. Claritin) or other antihistamines or cough/cold medications as needed. No medications will be provided without explicit permission and a physician's order. Please provide physician's orders for all approved OTC medications.

Name/Category of OTC medication	Special Instructions

(Please attach more pages if needed)

Note to Parents/Guardians: All OTC medications that are not FDA approved will be confiscated.

B. Authorization for the School to Administer Prescription Medication to the Student

Parent/Guardian may provide prescription medication to be administered to the student. Parents/Guardians must provide any prescription medication in its original container with the pharmacist's label, which includes the student's name, medication name, amount (dosage), and time schedules. Please complete the following information and provide physician's orders for all prescribed medications:

Name of medication	Dose	Administration Method	Directions/Time schedule	Special Instructions

Attach Physician's Prescription Medication Note

Note to Parents: Please attached **all prescribed medications** note to the Health Certificate. You will need a physician's note with the following:

1. Letter Head with Physicians Name, Title, Address, and Phone Number
2. Purpose of Medication (e.g., to treat/aid with chronic or acute health condition)
3. Name of Medication
4. Dose of Medication
5. Administration Method
6. Direction/Time Schedule (e.g. time/ with or without food)
7. Any special instructions

Important: Please note that any prescribed medication that is **NOT DECLARED** will be **confiscated and will need to be re-prescribed in the U.S.**

C. Authorization for Student to Carry and Self-Administer Emergency Prescription Medication at School or During School-Sponsored Activities.

In general, students are not permitted to carry or self-administer medications, unless a medical need exists for the student to carry or self-administer medication in connection with a serious health condition or illness that cannot be reasonably accommodated by keeping the medication with school staff. Requests to carry and/or self-administer medication will be reviewed on a case-by-case basis and must be approved in writing by the Head of School. Please complete the below if the student has a medical need to carry and self-administer the below indicated medication while at school or school events or field trips:

The following portion is to be completed by the prescribing physician:

I affirm that I am the above-named Student's physician or medical provider and that I have prescribed the use of [check one]:

- inhaled asthma medication(s)
- auto-injectable epinephrine (i.e. EpiPen®)
- insulin supplies

at the dosage, time and duration listed above, if applicable. I further affirm that I have provided the student with proper instruction in the use and self-administration of the medication/supplies.

To be completed by the physician:

I have examined the student named on this form and completed the physical and wellbeing evaluation to be true and accurate. The student does not have apparent clinical contraindications to attend a boarding school. The student have been evaluated to practice and can participate in the sport(s) as outlined on this form (Question 7 & 20). A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

I affirm that the Student ' for whom these medication(s) are prescribed is under my care. I authorize the School and its authorized representatives to administer the medication(s) listed above in sections A, and B, which I have provided to the School in the original container. I authorize the Student to carry and self-administer the medication(s)/supply listed in section C. In the event that a student is unable to administer medication(s)/supply list in Section C without supervision by a School Personnel, I agree that the Student will be assisted by School Personnel.

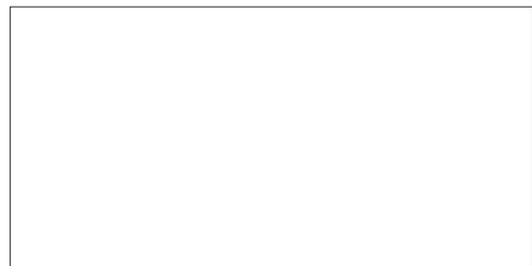
I agree that it is my responsibility to ensure that the School is provided with unexpired, properly labeled doses/supplies and that the Student has been trained on the dosing schedule. I acknowledge and agree that I will immediately notify the School by telephone and in writing of any changes in the Student's medication needs. I authorize the School to consult with the Student's physician/medical provider regarding any questions related to the Student's medication/supplies. I acknowledge that the Student must not share the medication(s)/supplies with others and that both I, and the Student, must adhere to all School procedures and rules concerning the handling and administration of such medication(s)/supplies.

Important! The examining physician cannot be a parent or relative of the student. Each Health Certificate will be examined by EF Academy. Any questions concerning the information contained here will be forwarded directly to the examining physician.

Physician (name in print): _____ Telephone: _____

Email: _____ Postal code and city: _____

Address: _____



Signature of physician

Date of examination:

Physician Stamp:

To be reviewed and filled out by the parents or guardian:

Medical release—Parents please read:

We certify that the records above are complete and accurate. We realize that any misstated or omitted information regarding our son/daughter’s medical/psychological history may affect his or her acceptance to or continued participation in EF Academy programs. We also understand that our son/daughter must complete all inoculations/testing per the requirements stated on this certificate. Should there be any new developments in our child’s medical or mental health after the submission of this form and prior to departure, we agree to inform EF Academy immediately. Failure to comply with these requirements may also affect his or her acceptance to or continued attendance in EF Academy.

We hereby give our full consent for our son/daughter to receive any medical/mental treatment or to undergo any emergency operation which is determined by a medical/mental health professional and may become necessary during his/her stay abroad. This includes shots or inoculations. Should the need arise for our child to be examined by a medical or mental health professional, these evaluations will not be confidential. We, the parents or guardian, authorize the direct disclosure of these evaluations and records to EF Academy and/ or its affiliates. If the student is age 18 or over his or her signature on this document also constitutes agreement to the direct disclosure of the said records. We also accept full responsibility for any medical expenses for our son/daughter which are not covered by his/her insurance policy.

Dispensing of Medication—Parents please read:

We accept full responsibility for any medical expenses for our son/daughter which are not covered by his/her insurance policy. The undersigned parent/guardian consents to EF Academy’s medical staff providing the student with non-prescription medications as outlined by the examining physician in the Certificate of Health. If your child comes to school with any medication, it must be accompanied by a valid prescription from your child’s doctor. Please be aware that any medication that your child brings to school that is not approved for use in California will be subject to confiscation.

To administer and oversee the medical care of the student, the undersigned parent/guardian grants local hospitals and urgent care facilities permission to share information on the medical treatment that they provided, including lab results and prescriptions, to EF Academy’s medical staff.

Release of liability and covenant not to sue:

To the fullest extent permitted by law, I voluntarily release and covenant not to sue EF International Academy, Inc., its parents, subsidiaries and affiliates, along with its and their trustees, officers, directors, employees, agents, representatives, coaches, volunteers, insurers, independent contractors (the “Released Parties”) from any and all claims and liabilities that arise out of, or relate to, the administration of prescription or non-prescription medications to the Student consistent with the terms of this Form, or the Student’s self-administration of medication(s) while at School, School-related events, or field trips.

Assumption of risk

I understand and acknowledge that certain risks are inherent in taking both prescription and non-prescription medication(s) and assume responsibility for any such risks associated with the Student taking any medication(s). I acknowledge that the risks to the Student include, but are not limited to, mild or severe adverse physical reaction to the prescription and/or non-prescription medication provided (including emotional/psychological harm), permanent and temporary disability, and death. I assume all risks arising out of, or relating to the School (its agents or employees) providing to the Student or the Student self-administering prescription and/or non-prescription medication consistent with the terms of this form/physician’s instructions, whether described above, known or unknown and inherent or otherwise.

I agree that the Student will also assume these risks and any other risks arising out of, or relating to, the School (its agents or employees) providing to the Student or the Student self-administering prescription and/or non-prescription medication(s) consistent with the terms of this form, whether described above, known or unknown and inherent or otherwise.

Use of health record

The above confidential information is complete, true and correct. The Undersigned hereby give(s) permission for this information to become part of the Student’s educational record and gives permission to the School to share the Student’s medical information with School personnel or other medical professionals who have legitimate educational and/or safety interests in this information.

Counterparts

This Form may be executed in any number of counterparts, each of which shall be deemed a duplicate original when all counterparts are executed, but all of which shall constitute a single instrument, and signatures submitted by electronic means (such as PDF version) or fax, shall be deemed the equivalent of original inked signatures.

I have carefully reviewed this form and fully understand its contents (including that this form contains certain releases of liability) and agree thereto.

 Mother / Father / Legal Guardian’s name in block capitals

 Mother / Father / Legal Guardian’s name in block capitals

Student name in block capitals

Signature

Signature

Signature (required for students aged 18 and over only)

Place/Date

Place/Date

Place/Date