



EF ACADEMY

Health Certificate New York Campus

To Parents

The information on this form is confidential and is requested to be able to care for your child during their time at EF Academy.

To the examining physician

Important: This form must be fully filled out. Please do not leave any blank spaces. 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.

Family Name: _____ First Name(s): _____

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

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

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

2. Student's Vision: ____ / ____ Date of Last Exam: _____ Student uses glasses Student uses lenses

3. Will the student be required or encouraged to seek any type of medical attention, treatment or check-ups while at school? Yes No

If yes, please explain: _____

4. Will the student be required or encouraged to take any type of prescription or non-prescription drugs, vitamins or supplements? Yes No

No If yes, please specify and complete the mandatory Medication Addendum: _____

5. 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): _____

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

If epi-pen is prescribed, student should bring 2 (1 for self-carry and 1 for the Health Center).

7. 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":

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Serious or persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils removed	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Serious persistent headache	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or digestive system	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Genito-urinary system	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart or blood vessels	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: if yes, what			Vertigo or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal organs	<input type="checkbox"/>	<input type="checkbox"/>
kind? Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Any disease, impairment or abnormality of:			Skin (acne, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Eyes or sight	<input type="checkbox"/>	<input type="checkbox"/>	Lungs, respiratory system	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Ears or hearing	<input type="checkbox"/>	<input type="checkbox"/>	Bones, joints or locomotor system	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Dental condition	<input type="checkbox"/>	<input type="checkbox"/>	Brain or nervous system	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils, nose or throa	<input type="checkbox"/>	<input type="checkbox"/>	Blood or endocrine system	<input type="checkbox"/>	<input type="checkbox"/>
						Musculoskeletal system	<input type="checkbox"/>	<input type="checkbox"/>
						Immunocomprised	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain, and include other medical, physical conditions not listed above: _____

8. 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 (e.g., Motrin, Advil, Nuprin)	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic cream (e.g., Bacitracin)	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen (e.g., Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone cream	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine (e.g., Benadryl)	<input type="checkbox"/>	<input type="checkbox"/>	Allergy (e.g., Claritin, Zyrtec)	<input type="checkbox"/>	<input type="checkbox"/>
Antacid (e.g., Tums, Gelusil)	<input type="checkbox"/>	<input type="checkbox"/>	Oral products 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	<input type="checkbox"/>	<input type="checkbox"/>
Anti-diarrheal (e.g., Immodium)	<input type="checkbox"/>	<input type="checkbox"/>			

9. 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 above, please give a detailed explanation: _____

10. Has this student ever been prescribed psychiatric medications? Yes No

If yes, please provide details regarding the specific medication(s) prescribed and the duration for which it was/is being taken:

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 explain: _____

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

14. If yes, please explain: _____

15. Has the student ever been diagnosed with one or more of the following conditions:
 Dyslexia Dyscalculia Dyspraxia Attention Deficit Hyperactivity Disorder (ADHD) Specific Learning Difficulties
 None of the above

If yes, please give details: _____

16. Does the student have any other health limitations, any pertinent medical information or, communicable disease that the student is currently or has been previously treated for? Yes No

If yes, please explain: _____

17. Inoculations

Please complete all sections!

All students traveling to the states of New York or California are required to get all vaccines listed below prior to departure. Without these inoculations a student cannot legally register in a U.S. high school. It is important to write month, day and year. If the student arrives without complete inoculations, the student's parents or legal guardians are responsible for any and all costs incurred. Without completed inoculations, students cannot attend classes.

Vaccine	Requirement	Please write Doses Received as Month/Day/Year (mm/dd/yy)				
		1st Dose	2nd Dose	3rd Dose *	4th Dose **	5th Dose
DTap - Diphtheria/ Tetanus/acellular Pertussis	5 doses (one of them after the student's 4th birthday)	required	required	required	required	required

*If 1st dose received after 1st birthday, only 3 doses required

**If 4th dose received after 4th birthday, only 4 doses required

Oral/inactivated Polio	4 doses (at least 1 after the 4th birthday)	required	required	required	required
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If the student has received the oral 3-dose Polio series and it was not mixed with doses of the Inactivated poliovirus vaccine (IPV), please tick this box and write the dates above

Hepatitis B	3 doses (4 if the third dose was given before the student was six months old)	required	required	required	
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If the student has received 2 doses of either Twinrix (Only applicable for 18+) or Recombivax between the years of 11 & 15, please tick this box and write the dates above

Vaccine	Requirement	Please write Doses Received as Month/Day/Year (mm/dd/yy)			Date of disease mm/dd/yy
		1st Dose	2nd Dose		
Measles	2 doses required, both after 1st birthday, unless disease is documented	required	required	or	required
Mumps		required	required		required
Rubella		required			required
Chicken Pox/Varicella		2 doses required unless disease is documented	required		required
Meningococcal ACWY	Unless disease is documented, 2 doses required, 1 before the student begins Grade 9 and 1 after the student turns 16. 1 dose is required if the student is over 16 and has never received a dose before.	required	required		required
Tdap (booster shot for DTap)	1 dose after 11th birthday (if dose was received after age 7, it is still meets the requirement).	required	required		required

These requirements are subject to change at any time if the state(s) opt to enact alterations. The Meningococcal B vaccine is strongly recommended for communal living environments. EF Academy will do our best to make families aware of changes as soon as possible.

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

19. Has the student ever received a BCG inoculation? Yes No

If yes, please state the date: _____ (date of inoculation mm/dd/yy)

US School Nurse: Please note that a BCG inoculation is NOT required.

20. Mandatory TB Test (should be administered within 1 year of expected school start date, or an additional test may be required for school enrollment upon arrival in the US) If your country is on the list of outbreaks, a test is required yearly.

Blood Test (copy of blood test results required): _____ (date of test mm/dd/yy)

Did the Blood Test indicate that the student may have TB? Yes No

If yes, a chest X-ray must be administered. Please state the date of the chest X-ray: _____ (date of test mm/dd/yy)

Did the chest X-Ray indicate that the student has active or contagious TB?(X-ray report is required to be included) Yes No

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

22. May the student participate in athletics? Yes No

List restrictions, or mark "none": _____

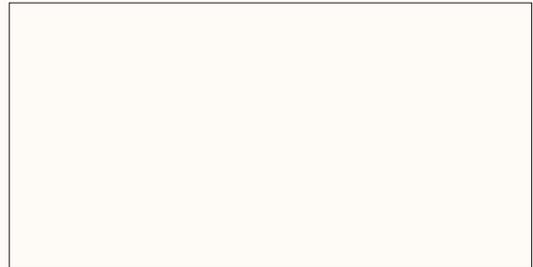
23. Please note that students must be able to operate independently at EF Academy Boarding Schools in the US. Based on the status of the student's physical and mental health, may this student travel to and study at an independent boarding school in the US? Yes No

Physician (name in print): _____

Telephone: _____

Address: _____

Postal code and city: _____



Signature of physician

Date of examination:

Physician Stamp:

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.

Medical release - To be filled out by the parents or guardian:

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 New York or 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.

 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



EF ACADEMY

Authorization for the School to Administer Medications

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

Parents/Guardians may approve EF International Academy, Inc. (“School”) to provide OTC medications to be administered to their child:

_____ (“Student”)

while at School, School-related activities, or field trips. Any OTC medications provided by the Parents/Guardians must be in the original container and labeled with the Student’s name, medication name, amount (dosage), and time schedules. Please complete the following information for OTC medication to be provided by the Parents/Guardians for self-administration:

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

(Please attach more pages if needed)

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. Benadryl) 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

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. The School will not accept medication brought to the School in baggies, envelopes, or hand-labeled containers. 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

(Please attached more pages if needed)

To be completed by the prescribing physician:

I affirm that the Student for whom these medication(s) are prescribed is under my care.

Name of Physician in BLOCK capitals	Signature of Physician
Physician's Street Address	Telephone
City/State/Zip+4 Code	Date

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 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.

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 by Nursing Department. 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.

Name of Physician in BLOCK capitals	Signature of Physician
Physician's Street Address	Telephone
City/State/Zip+4 Code	Date

I authorize the Student to carry and self-administer the medication(s)/supplies listed in section C, above, which I have marked to be carried and self-administered by the Student. I agree that it is my responsibility to ensure that the Student is provided with unexpired, properly labeled doses/supplies and that the Student has been trained to administer/use the medication(s)/supplies without supervision by School personnel. In the event that the Student is unable to administer the medication(s)/supplies without supervision by School personnel, I agree that the Student will be assisted by School personnel. 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.

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 its 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

Signature

Signature

Place/Date

Place/Date