Keio Academy of New York
US-JAPAN Summer Cultural Experience 2016
HEALTH REPORT FORM

PP.1-3 must be filled out and signed by a parent/guardian.

PP.1-3は保護者の方がご記入下さい。

Participant Name: _____ **Application Confirmation #:** _____
Last Name **First Name** **Middle Name**

Date of Birth: _____ Gender: ____Male ____Female Social Security Number (if any): _____
month / day / year

Home Address: _____
Street Address City State Zip

Parent/Guardian: _____ **Phone: (home)** _____ **(cell)** _____
Last Name **First Name**

Home Address: _____
(If different from above) Street Address City State Zip

Business Address: _____ Phone: _____
Street Address City State Zip

Second Parent, Guardian, or Emergency Contact: _____ **Relationship:** _____
Last Name **First Name**

Home Address: _____ Phone: _____
Street Address City State Zip

Business Address: _____ Phone: _____
Street Address City State Zip

Mandated by State

Parent/Guardian Authorizations:

This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all program activities except as noted.

Consent for Treatment and Transportation:

I hereby give permission to the authorized personnel of the Keio Academy Summer Program to provide routine health care, administer prescribed medication/s and seek emergency medical/dental treatment including laboratory or diagnostic tests if needed.
I agree to the release of any records necessary for insurance purposes.
I give permission to the program to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Keio Academy of New York to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for field trips. I also understand and agree to abide by any restrictions placed on my child's participation in program activities.

PARENT'S SIGNATURE
保護者のサイン

Signature of parent/guardian: _____
(Please do not forget to sign and date. 署名と日付の記入を忘れずに)

Printed Name: _____

Date: _____

HEALTH HISTORY

Must be completed by a parent/guardian　保護者の方がご記入

Restrictions:

The following dietary restriction(s) apply to my child: (Please check.)

☐ NONE

☐ Does not eat red meat　☐ Does not eat pork　☐ Does not eat eggs

☐ Does not eat poultry　☐ Does not eat seafood　☐ Does not drink milk or eat dairy products

☐ Others (specify) _____

General Questions: (Please check YES or NO and explain "YES" answers in the space below.)

My child has/has had:	YES	NO		YES	NO
1. recent injury, illness or infectious disease 最近の怪我、最近罹った病気または感染病	☐	☐	14. high blood pressure　高血圧	☐	☐
2. any surgery/hospitalization　手術/入院	☐	☐	15. heart disease/heart murmur　心臓病/ 心雑音	☐	☐
3. eye problems/vision loss　目の病気/視力低下	☐	☐	16. an orthodontic appliance to be brought to the program 歯科矯正中	☐	☐
4. nosebleed　鼻血	☐	☐	17. skin problems (e.g. itching, rash, acne) 皮膚の病気　(例：かゆみ、発疹、にきびの治療中)	☐	☐
5. frequent headaches　頻繁に起こる頭痛	☐	☐	18. diabetes　糖尿病	☐	☐
6. head injury/concussion　頭部損傷/脳震盪	☐	☐	19. asthma/ respiratory problem　喘息/呼吸器疾患	☐	☐
7. unconsciousness/fainting spells　意識不明/ 失神	☐	☐	20. mononucleosis in the past 12 months 12ヶ月以内の単核球症感染	☐	☐
8. eyeglasses, contact lenses, or protective eye wear 眼鏡、コンタクトレンズ、その他	☐	☐	21. diarrhea/constipation　下痢/便秘	☐	☐
9. ear infections/hearing loss 中耳炎(内、外)/聴覚障害	☐	☐	22. eating disorder　摂食障害	☐	☐
10. dizziness　めまい	☐	☐	23. an abnormal menstrual history　生理不順	☐	☐
11. nausea/vomiting　吐き気、嘔吐	☐	☐	24. problems with joints (e.g. knees, ankles)　関節の障害	☐	☐
12. seizures　てんかん	☐	☐	25. back problems　腰痛	☐	☐
13. chest pain during or after exercise　運動中/後の胸部痛	☐	☐	26 fractures/dislocations　骨折/ 脱臼	☐	☐
27. Has your child ever had emotional difficulties or behavioral problems? ☐**YES** ☐**NO** 精神面、行動面で問題ありと診断されたことがありますか。					

Please explain any "YES" answers, noting the number of the question. Also use this space to provide any additional information about your child's behavior or physical, emotional, or mental health about which the program staff should be aware.

_____

_____

_____

PARENT'S SIGNATURE
保護者のサイン

Participant Name: _____

Signature of parent/guardian: _____
(Please do not forget to sign and date.　署名と日付の記入を忘れずに)

Date: _____

CONCUSSION MANAGEMENT

Parent's signature required　保護者のサイン必修

Though Keio Academy of New York takes reasonable care to prevent summer program participants' injuries, we recognize that concussions and head injuries are among the most commonly reported injuries in children and adolescents who participate in interscholastic athletic activities, physical education classes, and extracurricular activities. Therefore, Keio Academy of New York adopts the following policy to assist in the proper evaluation and management of head injuries.

A concussion is a brain injury and is defined as a complex pathophysiological process affecting the brain, induced by biomechanical forces. Recovery from concussions will vary case by case. Avoiding re-injury and over-exertion until fully recovered is the cornerstone of proper concussion management.

Any participant who is believed to have sustained a concussion or who is demonstrating signs, symptoms, and behaviors consistent with a concussion while participating in a summer program activity shall be immediately removed from the activity and be evaluated as soon as possible by a certified health care professional.

No such participant shall return to the summer program activity while experiencing symptoms consistent with those of a head injury, nor resume any activity until he or she has been symptom-free for not less than 24 hours. The authorized medical personnel will make the final decision regarding return to the activities.

PARENT'S SIGNATURE
保護者のサイン

I read and understand the above information on Concussion Management.

Participant Name: _____

Signature of parent/guardian: _____ **Date:** _____
(Please do not forget to sign and date.　署名と日付の記入を忘れずに)

OTC MEDICATIONS

Parent's signature required 保護者のサイン必修

Please circle YES if medication is allowed to be given.
Please circle NO if medication is not allowed to be given.

1. Acetaminophen（アセトアミノフェン）	for fever/pain/headache （解熱・鎮痛剤）	**Yes / No**
2. Ibuprofen（イブプロフェン）	for fever/pain/menstrual cramps （解熱・鎮痛剤）	**Yes / No**
3. Benadryl（ベネドリル）	for allergy （蕁麻疹・アレルギー用薬）	**Yes / No**
4. Loratadine（ロラタジン　　）	for hay fever and allergy （花粉症・アレルギー用薬）	**Yes / No**
5. Phenylephrine（フェニレフリン）	for nasal congestion （鼻づまり緩和剤）	**Yes / No**
6. Robafen DM（デキストロメトルファン・グアイフェネシン）	for cough （咳止め）	**Yes / No**
7. Mylanta/Rolaids（炭酸カルシウム・水酸化マグネシウム）	for acid and gas （胃薬・制酸剤）	**Yes / No**
8. Milk of Magnesia　（水酸化マグネシウム）	for acid and laxative （便秘薬・緩下剤）	**Yes / No**
9. Imodium（ロペラミド）	for diarrhea （下痢止め）	**Yes / No**
10. Simethicone（シメチコン）	for gas relief （腹痛の緩和・整腸剤）	**Yes / No**
11. Bismuth Tablet（サリチル酸ビスマス）	for nausea （吐き気止め）	**Yes / No**
12. Driminate（ジメンヒドリナート　　）	for motion sickness （乗物酔い薬）	**Yes / No**

PARENT'S SIGNATURE
保護者のサイン

Participant Name: _____

Signature of parent/guardian: _____ **Date:** _____
(Please do not forget to sign and date.　署名と日付の記入を忘れずに)

PHYSICIAN'S SECTION

PP.4-6 must be completed and signed by an examining physician.

PP.4-6は担当医による記入必須

Application Confirmation Number: _____

Participant's Name: _____
Last Name First Name Middle Name (if any)

Date of Birth: _____

Blood Pressure: _____ **Pulse:** _____ **Respiratory Rate:** _____ **Temperature:** _____˚F

Weight: _____ **lbs.** **Height:** _____ **inches**

I. ALLERGIES: (Please check and list below.)

☐NONE

☐Food: _____ ☐Medication: _____

☐Seasonal ☐Insect/Animal: _____ ☐Other: _____

Allergic Reaction: ☐Anaphylaxis (details) _____ ☐Other Reaction (details) _____

Allergy Management: _____

II. CHRONIC DISEASE ASSESSMENT: (Please check and describe.)

☐**NONE**

Asthma: ☐None ☐Mild Asthma ☐Moderate Asthma ☐Severe Asthma ☐Exercise Induced Asthma

Diabetes: ☐None ☐Type I ☐Type II

☐**Seizure Disorder:** _____ ☐**Atopic Dermatitis/Skin Disorder:** _____

☐**Other:** _____

Significant Medical/Surgical History: ☐None Specify, if any _____

The student ☐is ☐is not able to participate in strenuous physical activities.

Describe any limitations or restrictions on program activities: _____

III. CONTAGIOUS DISEASE ASSESSMENT: (Please check any disease the child has had.)

☐ NONE ☐ Measles ☐ Chicken Pox ☐ German Measles ☐Mumps Hepatitis ☐A ☐B ☐C

☐ Meningitis ☐ Polio ☐ Pertusis ☐Other contagious disease: _____

IV. REQUIRED IMMUNIZATIONS:

The applicant must have received all of the following immunizations in order to participate in the program. Exact dates are required for all immunizations. Please submit proof of immunization or immunity by titer (blood test if available).

Required 1) **Meningococcal Vaccine** If you are 16 or older, and had the vaccine before 16, a 2nd dose is required. A minimum of 8 weeks is required between doses.

☐ 1st dose Date (MM/DD/YY): _____

☐ 2nd dose (if 16+) Date (MM/DD/YY): _____

Required 2) **Varicella** 2 doses, at least 4 weeks apart

☐ 1st dose Date (MM/DD/YY): _____

☐ 2nd dose Date (MM/DD/YY): _____

☐ Immune by titer: Date (MM/DD/YY): _____

Result: ☐ Negative ☐ Positive

Required 3) **Tdap (Tetanus/ Diphtheria/Pertussis)** 1 dose

☐ Date (MM/DD/YY): _____

CONTINUED PHYSICIAN'S SECTION
健康診断書は医師に記入とサインしてもらって下さい。

Application Confirmation Number: _____

Participant's Name: _____

Required 4) **Hepatitis B** 3 doses of at least 0.5ml (2 doses sufficient if not enough time for 3rd dose before program.)
- ☐ 1st dose Date (MM/DD/YY): _____
- ☐ 2nd dose Date (MM/DD/YY): _____ Must be at least one month after first dose.
- ☐ 3rd dose Date (MM/DD/YY): _____ Must be at least six months after second dose.

Required 5) **Measles** (2 doses after 1 year of age), **Mumps** (2 doses after 1 year of age), and **Rubella** (1 dose after 1 year of age) (doses must be at least 4 weeks apart)

MMR - 2 doses required on or after 1st birthday
- ☐ 1st dose Date (MM/DD/YY): _____
- ☐ 2nd dose Date (MM/DD/YY): _____

☐ Immune by titer
Date (MM/DD/YY): _____
Result: ☐ Negative ☐ Positive

OR

Measles - 2 doses required on or after 1st birthday
- ☐ 1st dose Date (MM/DD/YY): _____
- ☐ 2nd dose Date (MM/DD/YY): _____

☐ Immune by titer: Date (MM/DD/YY): _____
Result: ☐ Negative ☐ Positive

Mumps - 2 doses required on or after 1st birthday
- ☐ 1st dose Date (MM/DD/YY): _____
- ☐ 2nd dose Date (MM/DD/YY): _____

☐ Immune by titer: Date (MM/DD/YY): _____
Result: ☐ Negative ☐ Positive

Rubella - 1 dose required on or after 1st birthday
☐ Date (MM/DD/YY): _____

☐ Immune by titer : Date (MM/DD/YY): _____
Result: ☐ Negative ☐ Positive

V. REQUIRED TESTS:
The below tests are required prior to participation in the program, except as noted below.

TB Mantoux Test (PPD) (Participants *born in America* may have this test waived by attaching a letter from their physician stating that the test is not necessary.)

Date of PPD: (BCG not accepted.)
_____/_____/_____

Result: _____ mm induration

Date read: _____/_____/_____
(New test within 1 year of program required if results from previous test were negative.)

IF POSITIVE PPD, CHEST X-RAY REQUIRED
(X-ray must be within 1 year from program start date.)

Date of chest x-ray:
_____/_____/_____

Results:
☐ Normal
☐ Abnormal

Did participant take INH medication?
☐ Yes ☐ No

If yes, date INH started:
_____/_____/_____

Date INH completed:
_____/_____/_____

VI. HIGHLY RECOMMENDED IMMUNIZATIONS: (Please write dates of vaccinations if applicable.)

Highly Recommended Immunizations	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE	Check box if not vaccinated or had disease (indicate date/year of disease)
DTP (Diphtheria/Tetanus/Pertussis)：三種混合						
Td /DT (Diphtheria/Tetanus) ：2 種混合						
POLIO (IPV or OPV)： 小児マヒ						
INFLUENZA：インフルエンザ						

Please attach a copy of the participant's immunization record.

CONTINUED PHYSICIAN'S SECTION
医薬品を持参される場合、医師と保護者、2 人のサインが必要です。

Application Confirmation Number: _____

Participant's Name: _____

DOCTOR'S SIGNATURE
担当医のサイン

This form has been completed by a Licensed Medical Personnel/Physician.

_____
Physician's Printed Name **Physician's Signature**

_____
Address **Phone**

Date of Physical Examination: _____
(Exam must be done within 12 months prior to program attendance.
Please do not forget to sign and date. 署名と日付の記入を忘れずに)

VII. SELF CARE/SELF ADMINISTRATION:
Please list necessary medications and/or supplements the participant must bring to the program.

Medication/Supplement	Dosage	Frequency/Schedule

If you have listed any medications and/or supplements, physician and parent/guardian signatures are required below.
持参する薬やサプリメントなどがある場合、担当医と保護者お2人のサインが必要となります。

PARENT AND DOCTOR'S SIGNATURES
保護者と担当医のサイン

Self Care/Self Administration

Students who need to carry any medications/supplements dispensed by school nurse:
I request that the above named child be permitted to administer his/her medications/supplements under the supervision of a staff member of the program. She/he has been instructed in and understands the medications'/supplements' purpose, frequency, and appropriate method of use.

_____
Physician's Printed Name **Physician's Signature** **Date**

As I consider him/her responsible, I will not hold Keio Academy of New York personnel responsible for any problems that may arise with regards to my child's self-administered medication/supplements.

_____
Parent's Printed Name **Parent's Signature** **Date**