



2010 VILLAGER HEALTH HISTORY HOMETOWN, EUROPE

SESSION ATTENDING: (check one)
[] EE42 July 5-July 17
[] EE43 July 5-July 17
[] EE62 July 19-July 31
[] EE63 July 19-July 31
MAIL, FAX OR E-MAIL TO:
Concordia Language Villages
Attn: ELV
901 8th St S
Moorhead, MN 56562
Fax: +1-218-299-3807
E-Mail: elv@cord.edu

HEALTH HISTORY:
This form must be completed by the parent/guardian within six months of program participation. Provide adequate information so the Language Villages can work effectively with your child. Mail, fax or e-mail the completed form to the Language Villages office at least two weeks before the start date of your program and bring the signed original to Opening Day. Keep a copy of the completed form for your records; note changes and inform the Village dean in writing of any changes.
NOTE: There is no nurse or physician on our staff. Your child will be referred to a local provider if medical care is needed and you will be billed.

Name: _____
First Middle Last
[] Male [] Female Birth Date: _____
Day Month Year

PARENT CONTACT INFORMATION: We will call in an emergency or if we have questions about your child. Please provide contact information as well as information for an alternate contact person in case we are unable to reach you.

Parent Contact: _____
Preferred Phone: (____) _____ Alternate Phone: (____) _____
Country: _____ Fax: _____
E-Mail: _____
Alternate Contact: _____
Preferred Phone: (____) _____ Alternate Phone: (____) _____

ALLERGIES: Check those that apply to this villager.

_____ This villager has no known allergies.
_____ This villager has an allergy to the following food(s): _____
Describe the reaction and what should be done if this food is eaten.

_____ This villager is allergic to the following medication(s): _____
_____ This villager is allergic to the following substance(s): _____
Describe the reaction and what should be done if exposure occurs.

NUTRITION: Check those that apply to this villager.

_____ This villager eats a regular diet and is prepared to eat foods of different countries.
_____ This villager has the following diet restriction(s):
[] Needs a meal plan that supports his/her diabetes.
[] Will die (anaphylaxis) if s/he eats this food: _____
_____ This villager will eat a vegetarian option rather than a meat option.

BILLING INFORMATION FOR HEALTHCARE: Parents/guardians are financially responsible for healthcare given by a provider. Where should the bill for your villager's healthcare be sent?

Name: _____
Address: _____

If the Language Villages incurs a charge for your child's healthcare, we will bill you.

CHRONIC CONCERNS: Initial those that apply to this villager.

_____ This villager has no chronic health concerns and is capable of full participation in the program.

_____ This villager has the following chronic health concern(s):

- Asthma
 Bedwetting
 Diabetes

- Frequent colds
 Frequent Ear Infections
 Headaches

- Menstrual Cramps
 Sleepwalking
 Other: _____

Provide information about supportive healthcare needed for each checked item:

MEDICATION: Provide complete information. NOTE: Your villager is responsible for self-medicating. Bring enough medication to last the entire session. Prescription medications MUST be in pharmacy containers and appropriately labeled.

- This villager will not take any daily medications while attending the Language Villages.
- This villager takes routine medication (include vitamins) as follows (attach more information if needed):

Name of Medication	Reasons for Taking	Dose Taken & When

IMMUNIZATION HISTORY: Provide the month and year for each immunization. Starred (★) immunizations must be current.

Immunization	Date: Month(s) & Year(s)	Immunization	Date: Month(s) & Year(s)
Tetanus Booster★ (within 10 years)		Polio★	
Hepatitis B		MMR (Measles, Mumps, Rubella)★	
Haemophilus Influenza B			

GENERAL HISTORY: Check "Yes" or "No" for each statement

- Yes No This villager has had chicken pox.
- Yes No This villager has not had mononucleosis in the past twelve months.
- Yes No This villager has no history of illness, injury or surgery, which would affect participation.
- Yes No For girls: This villager knows about menstruation and has a normal menstrual history.

Use this space to explain statements for which "NO" was checked: _____

Name of villager's physician: _____ Office Phone: (____) _____ Country: _____

If your villager receives care for emotional, learning, and/or psychological concerns, provide information to help us work effectively with him/her:

Use this space to provide additional information about your villager's health: _____

Parent/Guardian Authorization for Healthcare: This health history is correct and accurately reflects the health status of the villager to which it pertains. The person described has permission to participate in all program activities except as noted by me and/or the examining physician. I give permission to the physician selected by Concordia Language Villages to order care and treatment related to the health of my child both for routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with others. I give permission to photocopy this form. In addition, the Language Villages has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Custodial Parent/Guardian: _____ Date: _____

