



**2010 VILLAGER  
HEALTH HISTORY  
HOMETOWN, BRAZIL**

**SESSION ATTENDING:** (check one)  
 January 11-16  
 January 18-23  
  
**STUDENTS SHOULD BRING THE COMPLETED AND SIGNED FORM WITH THEM TO THE VILLAGE.**  
  
**QUESTIONS?**  
Call: +1-218-299-4947  
-or-  
E-Mail: elv@cord.edu

**IMPORTANT:**  
1. This form must be completed and signed by the student's parent/guardian.  
2. Return it to the Language Villages' office at least two weeks before arrival.  
3. The Language Villages expects that students are in good health and capable of full participation in our program.

Name: \_\_\_\_\_  
                    First                                    Middle                                    Last

Male  Female

Birth Date: \_\_\_\_\_  
                                    Day                                    Month                                    Year

Country: \_\_\_\_\_

When was the villagers most recent **tetanus** shot?                      Month \_\_\_\_\_                      Year \_\_\_\_\_

Yes  No    Does the villager have **allergies**?  
If yes, what is the villager allergic to? \_\_\_\_\_  
\_\_\_\_\_

If yes, what should be done to treat the allergies? \_\_\_\_\_  
\_\_\_\_\_

Yes  No    Does the villager have **asthma**?  
If yes, what causes the asthma? \_\_\_\_\_

If yes, what is used to treat the asthma? \_\_\_\_\_  
\_\_\_\_\_

Yes  No    Is the villager taking any medication? If yes, please list below.

Name of Medication	Reasons for Taking	Dose Taken & When

**DIET RESTRICTIONS:**

Yes  No Are you a vegetarian (you do not eat meat)?

Yes  No Are you a vegan (you do not eat animal products)?

Other restrictions, please explain \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

We will call if there is a question about your child's health and/or in an emergency.  
Provide contact information for a parent/guardian who will be available during your villager's stay at the Language Villages.

Name of custodial parent: _____	Daytime phone: _____
Street address: _____	Evening phone: _____
City: _____	
State: _____	Country: _____
Parent e-mail address: _____	Fax number: _____

**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: \_\_\_\_\_

Use the space below to provide additional health information about your child.