



## PHYSICIAN'S STATEMENT OF HEALTH AND MENTAL HEALTH

***Must be filled out by your doctor***

Student's Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Has the applicant ever had any of the following? If yes, please provide the date and \*detailed information below, such as treatment, is the issue ongoing etc.)

Chicken Pox  Yes  No Date: \_\_\_\_\_

Contact dermatitis:  Yes  No

\*Details and explanation: \_\_\_\_\_

Measles  Yes  No Date: \_\_\_\_\_

Drug sensitivity (ie penicillin):  Yes  No

\*Details and explanation: \_\_\_\_\_

Mumps  Yes  No Date: \_\_\_\_\_

\*Details and explanation: \_\_\_\_\_

Rubella  Yes  No Date: \_\_\_\_\_

Epilepsy:  Yes  No

\*Details and explanation: \_\_\_\_\_

Malaria  Yes  No Date: \_\_\_\_\_

Febrile seizure:  Yes  No

\*Details and explanation: \_\_\_\_\_

Hepatitis  Yes  No Date: \_\_\_\_\_

Vertigo, dizziness:  Yes  No

\*Details and explanation: \_\_\_\_\_

Asthma  Yes  No Date: \_\_\_\_\_

\*Details and explanation: \_\_\_\_\_

Appendicitis  Yes  No Date: \_\_\_\_\_

Internal parasites:  Yes  No

\*Details and explanation: \_\_\_\_\_

Diabetes  Yes  No Date: \_\_\_\_\_

\*Details and explanation: \_\_\_\_\_

HIV  Yes  No Date: \_\_\_\_\_

\*Details and explanation: \_\_\_\_\_

COVID-19  Yes  No Date: \_\_\_\_\_

Allergies  Yes  No

Please list allergies:

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Has the student been treated by a doctor for any allergy symptoms:

Yes  No

Please describe symptoms and medication:

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\*Allergies: Can any of the reactions be life threatening?

Yes\*  No

Please describe:

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Learning Disabilities  Yes  No

Please provide details:

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Dyslexia/Word  Yes  No

Please provide details:

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ADD/ADHD  Yes  No

Please provide details:

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Sleepwalking  Yes  No

Please provide details:

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Migraine (with aura, nausea and vomiting)

Yes  No

Please provide details:

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Has the student ever been hospitalized?

Yes  No

Please provide details:

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Has the student ever consulted a medical specialist?

Yes  No

Please provide details:

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Is the student currently using any prescription drugs and/or medication?

Yes  No

If yes, give details and list specific drugs being taken.

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Will the student be using medication or other treatment or therapies for any of the above while abroad?

Yes  No

Please provide details:

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Has the student experienced disease, impairment or abnormality of any of the following?

\*If yes, please explain below.

Abdominal Organs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Genital-Urinary System	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bones/Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart or Blood Vessels	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood/Endocrine System	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidneys/Genitourinary System	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lungs/Respiratory System	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brain/Nervous System	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ears or Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsils, Nose or Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes or Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has the student ever suffered from, consulted with or been treated by a specialist for any of the following? If yes, please provide a clear explanation with details below.

Anxiety, Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Substance abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Attempted suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Behavioural problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-harm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\*If yes, please provide details (date of illness, treatment, whether issue is ongoing):

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Please describe any health issues this student may have or has had that may affect studies in Canada.

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Are there any restrictions on the student's participation in sports or other physical activities/physical education?

Yes       No

\*If yes, please provide explanation:

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## **Mental Health: What it means for international students**

Studying abroad takes courage. It requires a young person to jump into the unknown and get out of their comfort zone. They are away from their friends and family and in many cases delving into an entirely new way of living and perceiving the world. This adjustment takes time.

These extra pressures add to what is already considered to be a stressful period during a young adult's life. While studying abroad is a rewarding and enjoyable experience for students, bouts of depression and loneliness are not uncommon. As they make new friends, wade their way through coursework and live away from home for the first time in their lives, they need to suddenly adapt to completely new environments and routines and stressful situations can cause underlying mental health issues to rise to the surface.

### **Common Mental Health Issues**

Culture shock and homesickness are both common causes of depression and anxiety for international students. International students can be affected by mental health, whether they have underlying issues or not. The most common mental health issues among international students include: culture shock and homesickness, depression, anxiety, and bipolar disorder.

### **To the student's parents and family physician:**

1. Has your child recently experienced or is currently experiencing mood instability, self-injury, anxiety, or eating disorders?

Yes  No

If yes, please explain in detail.

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2. Has your child ever in the past had mental health concerns such as mood instability, self-injury, anxiety, or eating disorders?

Yes  No

If yes, please explain in detail, including when and how it was addressed.

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3. Has your child ever seen or talked to a psychologist or counselor?

Yes  No

If yes, please explain in detail including when and the reason(s) why.

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4. Does your child demonstrate behavioural conditions or addictions such as online/social media, gaming, drugs, alcohol, vaping, smoking?

Yes  No

If yes, please explain in detail.

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5. Has your child ever been expelled from school?

Yes  No

If yes, please explain in detail.

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Please provide your professional opinion of the student's physical health:

Excellent     Good  
 Fair             Poor

Please provide your professional opinion of the student's mental health:

Excellent     Good  
 Fair             Poor

**Medical Release Authorization**

I hereby authorize the Canadian Rockies Public Schools and the host parents to seek medical attention for me/my child in the event of sickness, accident, or other emergency during the program.

This authorization shall be valid for the entire duration of the student's enrollment at Canadian Rockies Public Schools.

**Declaration of Accuracy**

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the above student. I certify that the above information is complete and accurate and that I have provided all medical and mental health information and no information has been withheld.

I certify that the above mentioned student is fit emotionally and physically to engage in a high school program abroad.

**Medical practitioner must NOT be a direct family member of the applicant.**

Student's signature:

Date:

Parent's signature:

Date:

Doctor's signature:

Date:

Doctor's Office Stamp: