



**Keio Academy of New York**  
**US-JAPAN Summer Cultural Experience 2019**  
**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**

**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/had:	YES	NO	My child has/had:	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症	<input type="checkbox"/>	<input type="checkbox"/>	14. high blood pressure 高血圧	<input type="checkbox"/>	<input type="checkbox"/>
2. any surgery/hospitalization 手術/入院	<input type="checkbox"/>	<input type="checkbox"/>	15. heart disease/heart murmur 心臓病/心雑音	<input type="checkbox"/>	<input type="checkbox"/>
3. eye problems/vision loss 目の病気/視力低下	<input type="checkbox"/>	<input type="checkbox"/>	16. an orthodontic appliance to be brought to the program 歯科矯正中	<input type="checkbox"/>	<input type="checkbox"/>
4. nosebleed 鼻血	<input type="checkbox"/>	<input type="checkbox"/>	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)	<input type="checkbox"/>	<input type="checkbox"/>
5. frequent headaches 頻繁に起こる頭痛	<input type="checkbox"/>	<input type="checkbox"/>	18. diabetes 糖尿病	<input type="checkbox"/>	<input type="checkbox"/>
6. head injury/concussion 頭部損傷/脳震盪	<input type="checkbox"/>	<input type="checkbox"/>	19. asthma/ respiratory problem 喘息/呼吸器疾患	<input type="checkbox"/>	<input type="checkbox"/>
7. unconsciousness/fainting spells 意識不明/失神	<input type="checkbox"/>	<input type="checkbox"/>	20. mononucleosis in the past 12 months 12ヶ月以内の単核球症感染	<input type="checkbox"/>	<input type="checkbox"/>
8. eyeglasses, contact lenses, or protective eye wear 眼鏡、コンタクトレンズ、その他	<input type="checkbox"/>	<input type="checkbox"/>	21. diarrhea/constipation 下痢/便秘	<input type="checkbox"/>	<input type="checkbox"/>
9. ear infections/hearing loss 中耳炎(内、外)/聴覚障害	<input type="checkbox"/>	<input type="checkbox"/>	22. eating disorder 摂食障害	<input type="checkbox"/>	<input type="checkbox"/>
10. dizziness めまい	<input type="checkbox"/>	<input type="checkbox"/>	23. an abnormal menstrual history 生理不順	<input type="checkbox"/>	<input type="checkbox"/>
11. nausea/vomiting 吐き気、嘔吐	<input type="checkbox"/>	<input type="checkbox"/>	24. problems with joints (e.g. knees, ankles) 関節の障害	<input type="checkbox"/>	<input type="checkbox"/>
12. seizures てんかん	<input type="checkbox"/>	<input type="checkbox"/>	25. back problems 腰痛	<input type="checkbox"/>	<input type="checkbox"/>
13. chest pain during or after exercise 運動中/後の胸部	<input type="checkbox"/>	<input type="checkbox"/>	26. fractures/dislocations 骨折/脱臼	<input type="checkbox"/>	<input type="checkbox"/>
27. Has your child ever had emotional difficulties or behavioral problems? <input type="checkbox"/> YES <input type="checkbox"/> 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.

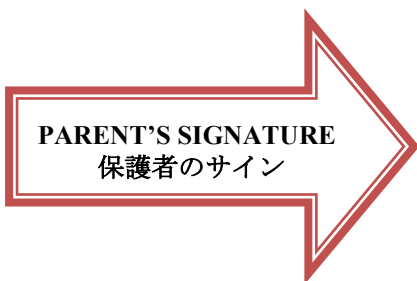
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**Participant Name:** \_\_\_\_\_

**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рил)	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アン・グアイフェネシン)	for cough (咳止め)	Yes / No
7. Tums (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

### 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 2<sup>nd</sup> dose is required. A minimum of 8 weeks is required between doses.

1<sup>st</sup> dose Date (MM/DD/YY): \_\_\_\_\_  
 2<sup>nd</sup> dose (if 16+) Date (MM/DD/YY): \_\_\_\_\_

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

1<sup>st</sup> dose Date (MM/DD/YY): \_\_\_\_\_  
 2<sup>nd</sup> 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 are sufficient if not enough time for 3<sup>rd</sup> dose before program. Any remaining doses may be required to be given during the program depending on the date of the last dose.)**

- 1<sup>st</sup> dose      Date (MM/DD/YY): \_\_\_\_\_
- 2<sup>nd</sup> dose      Date (MM/DD/YY): \_\_\_\_\_      Must be at least 4 weeks after first dose.
- 3<sup>rd</sup> 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 1<sup>st</sup> birthday**

1<sup>st</sup> dose      Date (MM/DD/YY): \_\_\_\_\_

2<sup>nd</sup> dose      Date (MM/DD/YY): \_\_\_\_\_

Immune by titer  
Date (MM/DD/YY): \_\_\_\_\_  
Result:  Negative     Positive

**OR**

**Measles - 2 doses required on or after 1<sup>st</sup> birthday**

1<sup>st</sup> dose      Date (MM/DD/YY): \_\_\_\_\_

2<sup>nd</sup> dose      Date (MM/DD/YY): \_\_\_\_\_

Immune by titer:    Date (MM/DD/YY): \_\_\_\_\_  
Result:  Negative       Positive

**Mumps - 2 doses required on or after 1<sup>st</sup> birthday**

1<sup>st</sup> dose      Date (MM/DD/YY): \_\_\_\_\_

2<sup>nd</sup> dose      Date (MM/DD/YY): \_\_\_\_\_

Immune by titer:    Date (MM/DD/YY): \_\_\_\_\_  
Result:  Negative       Positive

**Rubella - 1 dose required on or after 1<sup>st</sup> 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: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Did participant take INH medication?  
 Yes     No

Results:  
 Normal  
 Abnormal

If yes, date INH started:  
\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date INH completed:  
\_\_\_\_/\_\_\_\_/\_\_\_\_\_

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

Highly Recommended Immunizations	1 <sup>ST</sup> Dose	2 <sup>ND</sup> Dose	3 <sup>RD</sup> Dose	4 <sup>TH</sup> Dose	5 <sup>TH</sup> Dose	Check box if not vaccinated or had disease (indicate date/year)
DTP (Diphtheria/Tetanus/Pertussis) : 三種混合						
Td /DT (Diphtheria/Tetanus) : 2 種混合						
POLIO (IPV or OPV) : 小児マヒ						

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



**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。

**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



