HEALTH CLEARANCE FORM

Year of Travel: **2020**	Program: **5th Grade Japan Cultural Exchange**	Country of Travel: **Japan**
Student Last Name: ___________________ First Name: _________________ M.I.:_____ Gender: _________		
Parent/Guardian Last Name: ____________________________ First Name: __________________________		
Parent/Guardian Last Name: ____________________________ First Name: __________________________		

This **Health Clearance Form** allows 2019 5th Grade Japan Cultural Exchange coordinators and staff to identify participants with medical concerns, clarify their individual needs, and make preparations for adequate support. Candid responses will facilitate safeguarding your child's health and wellness while abroad. If your child has a medical or mental health condition that may be affected by participation in the program, we want to recognize it, discuss your needs and concerns, and respond appropriately within the limits of available resources and facilities.

A physical exam AND completion of this Health Clearance Form is REQUIRED for each student who plans to participate in a travel abroad program that is sponsored or approved by Oya No Kai, Inc. ("ONK" or "Oya No Kai"). **The physical exam must be completed between June 15, 2019 and December 15, 2019.** These requirements cannot be waived. Information about the student's health does not affect program admission; it will only preclude student participation if essential care is unavailable.

Multnomah County Student Health Centers provide comprehensive primary and mental health care services to all Multnomah County children ages 5–18 at no cost. A list of health center locations can be found at: https://multco.us/school/student-health-centers-locations-and-hours.

Narcotics, psychotropics, other stimulant drugs, and syringes are illegal and/or restricted in Japan and special permission must be obtained in advance from the Japanese government for a student bringing such prescriptions. Assistance will be available to parent/guardian(s) to secure the necessary approvals and certifications. Applications for governmental approval must be made no later than January 1, 2019. **It is not an option to have your child not take necessary medications on the trip unless specifically authorized by your child's physician/medical provider.***

There are FOUR parts to this **Health Clearance Form.** All Parts are **DUE to ONK by December 15, 2019.**

- **Part I: Guardian Authorization** (p 3-4). Completed by parent/guardian(s). Submit to ONK.
- **Part II: Personal Health History of Traveling Child** (pp 5-7). Completed by parent/guardian(s) and given to the physician or medical provider who conducts the physical exam.
- **Part III: Physician Health Report & Examination** (p 8). Completed by the physician/medical provider who conducts the physical exam. Submit to ONK along with Part II.
- **Part IV: Supplemental Physician's Report for Overseas Travel** (pp 9-10). If needed, completed by the physician/medical provider who completed Part III or other treating physician.

Please mail the **Health Clearance Form** to:

Oya No Kai, Inc.
5th Grade Japan Cultural Exchange Coordinator
PO Box 13786
Portland, OR 97213 *Attn: Health Clearance Form*

All application forms must be submitted by regular mail to the PO BOX. **Please DO NOT leave any application materials at school or in school cubbies.**

Privacy of Medical Information: The information you provide will be handled as private information and will be accessible only as necessary to the Exchange Coordinator, Trip Director and Trip Chaperones to prepare for the trip. While abroad, as needed, information can be shared with involved health/medical providers and students' host families.

Future Medical Problems: Should your child develop a significant health problem between the time you complete this form and begin the program, please promptly notify the Exchange Coordinator and provide an updated physician's report (if relevant).

Students with Disabilities: Oya No Kai is committed to ensuring that all students who are ready to travel based on trip requirements can participate. We will facilitate students with disabilities as much as possible within the constraints of resources available to Oya No Kai and our hosting establishments in Japan. Every effort will be made to make sure the student has a safe and enjoyable travel abroad experience regardless of ability.

Oya No Kai is committed to the health and safety of all our program participations. Preparation, prevention, and communication are key to keeping students safe and healthy. Thank you for fully disclosing your child's health history and completing this form, along with your medical provider.

*More information on Japan's restrictions on bringing medication into Japan for personal use can be found here:
https://jp.usembassy.gov/u-s-citizen-services/doctors/importing-medication/
https://www.mhlw.go.jp/english/policy/health-medical/pharmaceuticals/dl/qa1.pdf

Part I: Guardian Authorization

Student Name: ____

Country of Travel: **JAPAN** Program: **5th Grade Japan Cultural Exchange**

Gender: ____________ Height: ____________ Weight: __________

Physician or Medical Provider's Contact Information

Name: ____

Address:____

City: ________________________________ State: __________ Zip: ____________________

Telephone: ________________________________ Fax: ________________________________

Emergency Contact

Name: ___________________________________ Relationship: ___________________________

Address: ____

City: ___________________________________ State: __________ Zip____________________

Home Tel.: ______________________ Bus. Tel.: ___________________ Mobile__________________

Authorization to Release Health Records and Permission for Emergency Medical Treatment

I hereby authorize the physician or other medical provider completing Part III and/or Part IV of this Health Clearance Form to release any or all health records or information pertaining to my child, the above-referenced student, to Oya No Kai, Inc.

I hereby also authorize the release by Oya No Kai, Inc., of any information from my child's medical history, including but not limited to medical records, to the relevant program director, trip staff working directly with my child, and to medical providers in the event of an emergency.

I agree to be responsible for, and agree to pay upon demand, all medical costs and debts that may be incurred by, or on behalf of, my child during the trip and activities, including, but not limited to, all expenses not covered by insurance that occur as a result of any accident, illness or medical emergency involving my child.

I understand that, if my child has a medical, psychiatric or psychological condition that requires or has required treatment, I must discuss my plan to travel abroad with my clinician and inform Oya Na Kai, Inc.

I certify that I have read this Health Clearance Form, including all the instructions, and agree to abide by them. I certify that the information on this Health Clearance Form is accurate and complete. I acknowledge and agree that any failure to provide accurate and complete information will result in my child's not being able to attend the trip program or my child's dismissal from the trip program. I agree to notify Oya No Kai, Inc. of any material or relevant changes in my child's health that occur prior to the travel abroad program or while on the program.

____
Signature of Custodial Parent/ Guardian

____
Print Name of Custodial Parent/ Guardian

____
Date

____
Signature of Custodial Parent/ Guardian

____
Print Name of Custodial Parent/ Guardian

____
Date

Part II: Personal Health History of Traveling Student

Year of Travel: **2020** Program: **5th Grade Japan Cultural Exchange** Country of Travel: **Japan**

Student Last Name: ___________________First Name: _________________ M.I.:_____Gender: _________

Parent/Guardian Last Name: ____________________________First Name:__________________________

Parent/Guardian Last Name: ____________________________First Name:__________________________

Overseas trips can be an enriching experience as well as a physically and mentally challenging one. Mild or pre-existing health conditions can become serious for some students as they transition into an unfamiliar culture and environment. Parent/Guardian(s) must fully disclose their child's health history so that we may prepare them properly for their experience, make arrangements for any special accommodations if necessary, and in some cases, assess whether there may be any health reasons that a student should consider another program. Please give as much detail as possible in answering the following questions.

This Personal Health History MUST be complete when given to the evaluating medical provider. Disclose your child's health history to the medical provider performing the physical exam, even if you believe a condition is under control.

Please check "yes" if your child has experienced any of the following diagnoses or symptoms. Please give details below on any checked response, adding additional paper if necessary.

	YES		YES		YES
Abdominal problems (irritable bowel syndrome/chronic diarrhea)		**Celiac disease**		**Impulse control issues**	
ADD/ADHD/Attention Deficit Disorder		**Cerebral palsy**		**Joint problems**	
Anemia		**Crohn's disease**		**Migraines or severe headaches**	
Anxiety		**Depression**		**Recurrent dizziness/faintness**	
Arthritis		**Diabetes**		**Substance Use/Abuse**	
Asthma		**Eating disorder**		**Thyroid disorder**	
Autism/Asperger's (ASD)		**Epilepsy (seizures)**			
Back problems		**Gastrointestinal disorder**		**Allergy (please specify below)**	
Bipolar disorder		**Head injury/concussion**		**Hay fever allergy**	
Bladder/kidney problems, including bed wetting		**Heart murmur/disease**		**Bees/wasps/insect allergy**	
Bleeding/clotting disorder		**High blood pressure**		**Pet/animal dander**	
Blood disorder		**Immune system problems**		**Other allergy (please specify)**	
Cancer or leukemia		**Impaired use of any limbs**		**Other chronic disease (please specify)**	

Comment below on any condition(s) that you have checked "yes" above:

Please answer the following questions either 'yes' or 'no.' Do not leave any question blank.

1. Is your child currently taking any medications (including antigen/immunotherapy allergy injections)? If yes, please list and give details, including dosage and for what conditions. ☐ Yes ☐ No

2. Does your child have allergies or any allergic reaction that require your child to carry an EpiPen or other similar device? If yes, please give diagnosis and date. ☐ Yes ☐ No

3. Has your child ever been hospitalized? If yes, please give diagnosis and date. ☐ Yes ☐ No

4. Does your child have any permanent injury or physical disability? If so, please explain. ☐ Yes ☐ No

5. Does your child have any health requirements or dietary restrictions? If yes, please explain. ☐ Yes ☐ No

6. In the last two years, has your child received counseling or been treated for a mental health condition, substance abuse, or eating disorder? If yes, please explain. ☐ Yes ☐ No

7. Has your child had any diseases, surgical operations or significant injuries within the last five (5) years that could have an impact on your child's participation in this program? If yes, please explain. ☐ Yes ☐ No

8. Are there any recommended or planned surgical operations for your child between now and your date of departure? If yes, please explain. ☐ Yes ☐ No

9. Does your child have any conditions (including physical impairments or learning disabilities) that might restrict mobility or require special facilities or accommodation while abroad? If yes, please explain. ☐ Yes ☐ No

The signature below confirms that I agree that Oya No Kai may share this information with its medical and mental health consultants for the purpose of completing the health review process, and that all information contained is accurate and complete.

Each custodial parent or legal guardian of the Student Participant must sign below unless court documents proving sole custodianship are provided.

______________________________	______________________________
Signature of Custodial Parent/ Guardian	*Signature of Custodial Parent/ Guardian*
______________________________	______________________________
Print Name of Custodial Parent/ Guardian	*Print Name of Custodial Parent/ Guardian*
______________________________	______________________________
Date	*Date*

Part III: Physician Health Report and Examination

Year of Travel: **2020** Program: **5th Grade Japan Cultural Exchange** Country of Travel: **Japan**

Student Last Name: ____________________First Name: _________________ M.I.:_____Gender: _________

Parent/Guardian Last Name: _____________________________First Name:___________________________

Parent/Guardian Last Name: _____________________________First Name:___________________________

To the Examining Physician: Oya No Kai offers a cultural exchange program to Japan for students. The program includes a busy schedule not for leisurely travel. The weather will be hot and humid. Students will live with a host family in varying proximity to Western-style health facilities and psychological services. Please carefully consider the child's general fitness and physical and mental health in relation to the country, the type of program, and the conditions in which the student will be living. This report should be based upon an examination made on or after June 1, 2019. **Part IV** is to be used for further health information for any "Yes" answers given in this **Part III.** Please return this report to the student's parent/guardian(s) upon completion.

Please answer the following questions by circling "Yes" or "No". Do not leave any question blank. Please give details on any checked "Yes" response in Part IV.

1.	Is this student seriously underweight or overweight that would require special dietary restrictions?	Yes	No
2.	Is there a history of any eating disorder, such as bulimia or anorexia, within the last two years?	Yes	No
3.	Does this student have any allergies (including allergies to medication and/or food) that require prescribed medication/treatment?	Yes	No
4.	If this student has allergies, is there a history of asthma, anaphylaxis, and other dangerous allergic conditions?	Yes	No
5.	Is this student currently under medical treatment or taking medication?	Yes	No
6.	Does this student have any speech, hearing, eyesight, or physical impairment that requires special accommodation or treatment while the student is abroad?	Yes	No
7.	Has the student received counseling or mental health treatment within the last two years that could impact a chaperone/host family's ability to care for the student?	Yes	No
8.	Is there any congenital or chronic condition that may require additional treatment up through July 15, 2019?	Yes	No
9.	Are there limitations to physical activity? E.g. carrying luggage. If yes, please give details below.	Yes	No

Having examined the student/child and reviewed the student's past medical history and to the best of my knowledge, I agree that the above-named student is healthy enough to participate in the program indicated above.

Signature of physician or medical provider: ____

Printed Name: ___________________________________ Medical License No. ___________________________________

Address: ____ City: ________________State: ______

Zip: ______________ Telephone: _________________________________ Fax: ______________________________

Part IV: Supplemental Physician Health Report for Overseas Travel

(Must be completed by the physician/medical provider for any "Yes" answers given in Part III.)

NOTE TO PARENT/GUARDIAN(S) OF STUDENT: If your student has multiple medical/mental health conditions, ***a separate Part IV form must be submitted for each condition.*** For any treatment/medication, please also make sure to obtain a doctor's note containing your child's name.

Diagnosis: ____

I have treated this individual for the above condition:

- ☐ within the past six months
- ☐ within the last year
- ☐ more than a year ago (please specify date): ______________________________________

Year of Travel: **2020** Program: **5th Grade Japan Cultural Exchange** Country of Travel: **Japan**

Student Last Name: __________________First Name: ________________ M.I.:_____Gender: _________

Parent/Guardian Last Name: ___________________________First Name:_________________________

Parent/Guardian Last Name: ___________________________First Name:_________________________

Medications and dosage:

____

____

Stability of condition over the past five (5) years:

☐ stable without treatment/medication ☐ stable with treatment/medication ☐ not stable

☐ other:____

Please answer the following questions to the best of your knowledge.

Are there any limitations to the student's participation in a physically and emotionally rigorous overseas program?

Are there any predisposing medical, physical, or emotional factors that, under stress of international travel, may require treatment while the student is abroad?

If the student is taking any narcotic, psychotropic, or other stimulant drug, are there any alternative and effective treatments available? * *Narcotics, psychotropics, other stimulant drugs, and syringes are illegal and/or restricted in Japan and special permission must be obtained in advance from the Japanese government for a student bringing such prescriptions.**

In your provider opinion, with appropriate instruction, can this student's medical/health condition be supervised overseas by non-medically trained and non-English speaking adult(s)?

Further recommendations for care of this student while abroad:

Signature of physician or medical provider: ______________________________

Printed Name: ______________________________ Medical License No. ____________________

Address: ______________________________

City: ____________________ State: ______________ Zip: ______________

Telephone: ______________________ Fax:______________________