**Académie Ste. Cécile International School**

**925 Cousineau Rd. Windsor, Ontario, Canada N9G 1V8**

Tel. 1-519-969-1291 - Fax. 1-519-969-7953

**Medical History Form – Historia Clínica**

(to be filled out by parents of applicant – para ser llenada por los padres del solicitante)

Name MiddleName Last Name

Nombre Segundo nombre Primer Apellido

Address Street Number City Country Tel.

Dirección Calle Número Ciudad País Tel.

Birthdate Month Day Year

Fecha de nacimiento Mes Día Año

1. a) Underline the childhood diseases you have had:

Subraye las enfermedades que haya tenido durante su infancia

Smallpox - Viruela Whooping cough – Tos ferina Scarlet Fever – Fiebre escarlatina

Chickenpox - Varicela Measles – Sarampión

Mumps - paperas German measles - Rubeola

1. Explain any handicaps resulting from these – Explique si alguna de estas enfermedades ha ocasionado alguna incapacidad mental o física:

1. Underline any of the following that you have had – Subraye si ha padecido lo siguiente:

***Infections Operations - Operaciones Chronic Disorders or conditions – Padecimientos***

***Crónicos***

Appendicitis - Apendicitis Appendectomy - apendectomía Digestive - Digestivo

Hepatitis – Hepatitis Bone Refractions – Fractura de huesos Urinary – Aparato urinario

Colitis - Colitis Mastectomy - mastectomía Glandular - Glandular

Osteomyelitis – Osteomielitis Hernia - Hernia Hearing - Oído

Pneumonia - Neumonía Tonsilectomy - Amigdalotomía Heart - Corazón

Polio - Poliomielitis Others – otras \_\_\_\_\_\_\_\_\_\_\_\_\_ Mental - Mental

Rheumatic Fever – Fiebre reumática \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision - Visión

Smallpox - Viruela Skin - Epidermis

Tonsilitis - Amigdalitis Allergy - Alergias

Typhoid - Tifoidea Muscular - Muscular

Typhus - Tifo Nervous – Sistema nervioso

Tuberculosis - Tuberculosis Nose & Throat – Nariz y garganta

Malaria - Malaria Asthma - Asma

Others - Otras\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dermititis - Dermatitis

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sunstroke - Insolación

Others - Otros\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give detailed information regarding any of the above ailments you have had (dates, duration, effects, medications) – Por favor, registre detalladamente los padecimientos que haya tenido, con fechas, duración, medicamentos y tratamientos seguidos

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Note carefully any allergies and their precautions and medications – Registre con claridad alergias y los cuidados y medicamentos requeridos:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you been hospitalized in the past 5 years? If so, explain – se le ha hospitalizado en los últimos 5 años? Si es así. explique: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Has any member of your immediate family (grandparents, parents, siblings) had – Alguno de los miembros de su familia (abuelos, padres o hermanos) ha sufrido :

Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tuberculosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Immunizations, number of times administered and the date of the last vaccinations – Vacunas, número de dosis y fechas:

DPT / TD – Difteria y/o tifoidea 0 1 2 3 4 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Polio – Polio 0 1 2 3 4 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles - Sarampión 0 1 2 3 4 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

German Measles - Rubeola 0 1 2 3 4 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mumps - Paperas 0 1 2 3 4 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by a licensed physician following his examination of the applicant:**

**Para ser llenada por un médico luego de una evaluación al solicitante:**

1. Age - Edad\_\_\_\_\_\_\_\_\_\_\_\_ Height - Estatura\_\_\_\_\_\_\_\_\_\_\_ Weight - Peso\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex – Sexo \_\_\_\_\_ Pulse - Pulso \_\_\_\_\_\_\_\_\_\_\_\_ Blood Type – Tipo de sangre \_\_\_\_\_\_\_\_\_\_\_ Respiration – Respiración \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure – Presión \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Is there any present evidence of the following – Existe algún indicio de:

Diabetes - Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anemia – Anemia \_\_\_\_\_\_\_\_ Epilepsy - Epilepsia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatic heart - Reumatismo\_\_\_\_\_\_ Hernia - Hernia\_\_\_\_\_\_\_\_\_\_\_ Mental disorder – Enfermedades mentales\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis - Hepatitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tuberculosis - Tuberculosis\_\_\_ Communicable Diseases – Enfermedades contagiosas\_\_\_\_

3. Any present disorder, atrophy, or abnormality of – presenta alguna atrofia, desorden o anormalidad:

Vision - Visión\_\_\_\_\_\_\_\_\_ Digestive Tract – Aparato digestivo\_\_\_\_\_\_\_\_\_\_ Hearing - Escucha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart - Corazón\_\_\_\_\_\_\_\_ Nose or throat – Nariz o garganta\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal Organs – Organos abdominals\_\_\_\_\_

Skin - Piel\_\_\_\_\_\_\_\_\_\_\_\_\_ Respiration Tract – Aparato respiratorio\_\_\_\_\_\_\_ Muscular System – Sistema muscular\_\_\_\_\_\_\_\_

Blood - Sangre\_\_\_\_\_\_\_\_\_ Bones/joints – huesos/articulaciones \_\_\_\_\_\_\_\_\_\_ Nervous System – Sistema nervioso \_\_\_\_\_\_\_\_\_

Bed wetting – Enurecia \_\_ Tonsils & adenoids – Amigdalas y adenoides\_\_\_\_ Circulation System – Sistema circulatorio\_\_\_\_\_

4. Comments or recommendations – Comentarios y recomendaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Describe any loss of members, atrophies or abnormalities – Describa alguna amputación, artrofias o anormalidades \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6. Describe any prominent birthmarks – Describa marcas de nacimiento \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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7. Describe any treatment given to this applicant in the past 12 months – Indique algún tratamiento recibido en el ultimo año \_\_\_\_\_\_\_\_\_\_\_

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8. Does the applicant show any signs of nervous, mental or emotional abnormality (frequent nightmares, , sleep walking, nervous fatigue, moodiness, enureals, etc. – Presenta el solicitante síntomas de alteración nerviosa, mental o emocional como pesadillas, sonambulismo, fatiga nerviosa, depression, enurecia? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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9. Do you recommend that the applicant have any limitation of physical activity during this stay? – Sugiere alguna restricción en actividades físicas durante su estadía en la Escuela?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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10. Please list any prescribed medications, injections, vitamins, precautions or treatment for allergic reactions – Enumere los medicamentos, inyecciones, vitaminas, precauciones o tratamientos que el solicitante deba seguir en caso de reacciones alérgicas:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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11. In your opinion what is the general condition of this applicant´s health – En su opinion, cómo es el estado de salud del solicitante?:

Excellent - Excelente\_\_\_\_\_\_\_\_ Good – Bueno \_\_\_\_\_\_\_\_\_\_\_ Fair – Regular \_\_\_\_\_\_\_\_ Poor – Malo \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician – Nombre del médico:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address – Dirección \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City – Ciudad\_\_\_\_\_\_\_\_\_\_\_\_\_ Country - País \_\_\_\_\_\_\_\_\_\_\_ Tel.\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Examination – Fecha del examen: Month- Mes \_\_\_\_\_\_\_\_\_\_\_\_\_ Day- Día \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year – Año \_\_\_\_\_\_\_\_\_\_\_\_\_

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**SIGNATURE - FIRMA**