PEARSON COLLEGE
UWC

Medical Parent/Guardian Consent

This form is for College purposes only and will not be submitted to any other agency or organization. The information provided will be held in confidence as part of your health record at the College Health Centre.

Student's full name Ruiyan Huang

Date of birth: Day/Month/Year 15/02/2003 male ☐ female ☑ other ☐

Student's home address: Room 101, Block 20, Langshi Taihu, Longhe Road, Wujiang District, Suzhou City, Jiangsu Province, China

I/We Xiaqin Shen & Jian Huang, parent(s) / guardian(s) of Ruiyan Huang (the "Student"), consent to Lester B. Pearson College of the Pacific using or disclosing the medical information when necessary for the medical treatment of this student, or to enable Pearson College, or its employees to make reasonable and informed decisions regarding the participation or supervision of the student in programs offered by Pearson College.

Parents/guardians of all students are responsible for all expenses not covered by medical plans, such as dental and optical services, and prescription medications.

I/We have completed the medical report and believe that it discloses all necessary information about the health of my student.

I/We hereby authorize the Head of College or College Nurse or a delegate to act on my behalf in arranging necessary medical intervention by qualified medical practitioners for my dependent in the event of injury or illness.

Xiaqin Shen	06/28/2019	JianHuang	06/28/2019
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

MEDICAL INSURANCE COVERAGE (Canadian Students)
Please attach a photocopy of the Health Care card.

Medical Plan No. _____

DENTAL CARE
Please confirm that this student has had recent, appropriate dental care and all caries have been attended to.

If the student has braces, and in need of ongoing care by an orthodontist, the College Nurse will make the necessary arrangements for student to see an orthodontist.

Xiaqin Shen	06/28/2019	JianHuang	06/28/2019
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

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Medical Health History **CONFIDENTIAL**

This form must be complete and signed by a health care provider.

Student's full name Ruiyan Huang

Date of birth: Day/Month/Year 15/02/2003 male ☐ female ☑ other ☐

Record all immunization dates as per table below, and arrange for MMR and Tetanus/Diphtheria Booster if they have not been received between the ages of 13 – 15 yrs. The Canadian Immunization Guide highly recommends the Hepatitis B series, record the dates if they have been given, or start the series if possible and they can be completed at the College if necessary.

If, for any reason, the student has not had the following immunization, please arrange to start proceedings as follows: Initial immunization for Diphtheria, Tetanus, Polio (TdP injection) and the Measles, Mumps, Rubella injection. A second dose of Diphtheria, Tetanus, and Polio (TdP) should be administered two months later.

Students must present documentary evidence of immunizations for you to complete this form. Incomplete information will result in the student requiring immunizations at the College and the family will be charged the cost of these. The meningococcal vaccine is CAD $ 160.00 and the Hepatitis A and B series is CAD $ 200.00

Please give dates of the following immunizations:

Immunization	Date	Date	Date	Date	Date
DPT-Diphtheria, Pertussis, Tetanus	05/18/2003	06/18/2003	07/18/2003	08/16/2004	(Booster Date) 19/07/2017
Polio	04/18/2003	05/18/2003	06/18/2003	08/16/2004	12/06/2007
Hib	02/18/2004				
Hepatitis B (Series of 3)	02/15/2003	03/28/2003	08/18/2003		
Hepatitis A (Series of 2)	09/16/2004				
Or Hepatitis A and B Vaccine Twinrix (Series of 3)					
Chicken Pox	03/18/2004	05/12/2017			
MMR – Measles, Mumps, Rubella (2 doses required)	02/26/2005	05/12/2017			
Meningococcal Vaccine	05/27/2017				
Other (specify):					

If you have had a BCG vaccine please give the date. All students must have a turberculin (mantoux) (TB) test prior to admission and chest X-ray if TB test is positive.

BCG: _____ Date: 03/28/2003

Turberculin Test Result: _____ Date: _____

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Chest X-ray Result: _____ Date: _____

To be protected against the vaccine preventable diseases above, the immunization series must be completed before arrival at Pearson College including booster vaccines where appropriate.

Please check any of the following diseases the student has had:

☐	Measles	☐	Chicken Pox	☐	Hepatitis A
☐	Mumps	☐	Mononucleosis	☐	Hepatitis B
☐	Rubella	☐	Tuberculosis	☐	Hepatitis C

Other (please specify): _____

Please give dates of the following optional immunizations:

Immunization	Date	Date	Date	Date	Date
Yellow Fever					
Typhoid					
HPV					
Other (specify):					

Please check any of the following that the student has had or now has:

☐	Stomach or Intestinal Problems	☐	Asthma	☐	Seizure Disorder/Epilepsy
☐	Frequent or Severe Headaches	☐	Diabetes	☐	Rheumatic Fever
☐	Learning Disability	☐	Migraines	☐	Concussion/Head Injury
☐	Malaria	☐	Tuberculosis	☐	Ear/Nose/Throat Problems
☐	Orthopaedic Problems	☐	Mononucleosis (Glandular Fever)	☐	Hepatitis or Jaundice

Other conditions, disabilities, and/or comments: _____
_____
_____

Please indicate any allergies and the type of reaction:
Medications: NONE
Food: NONE
Environmental: NONE
Wasp/bee stings: NONE

Please list medications, including non-prescription, which the student takes regularly or will bring with them to the College. Please include birth control pills, vitamins and minerals:
NONE
_____
_____

Has the student ever required hospitalization for any surgical, medical or psychiatric illness?
Yes ☐ No ☑ If yes, please specify diagnosis & date: _____
_____

Has the student ever had a history of any mental illness, such as depression, anxiety, eating disorders (anorexia nervosa, bulimia), disturbance of mood, thought or behaviour? Yes ☐ No ☑
If yes, please describe: _____
_____

Has the student ever received counselling or psychiatric care? Yes ☐ No ☑
If yes, please describe: _____
_____

Please list any dietary concerns: Yes ☐ No ☑
If yes, please specify (eg. vegetarian, no beef): _____
_____

Are there any religious or spiritual practices which may impact health care? Yes ☐ No ☑
If yes, please specify: _____
_____

What is the student's sleep pattern? (eg. usual hours slept) usual hours slept

Any history of substance use (alcohol, cigarettes, drugs, other addictions)? Yes ☐ No ☑
If yes, please specify type, amount and frequency: _____
_____

If the student menstruates:
Age at onset of menarche: 13 Irregular Menstruation or Problems: Yes ☐ No ☑
If yes, please specify: _____
Abnormal pap smear?: Yes ☐ No ☐ not applicable ☑

Have parents, siblings, or grandparents had any of the following?:

	Yes	No	Relationship
Diabetes		No	
High Blood Pressure		No	
Heart Disease		No	
Stroke		No	
Depression/Mental Illness		No	
Cancer		Yes	grandparents
Orthopaedic Problems		No	
Asthma		No	
Tuberculosis		No	
Other (specify):		No	

If either parent or a sibling is deceased, please list relationship to student, age at death and cause of death:

_____
_____
_____
_____

If the biological family history is unknown, please check here ☐

A urine analysis, blood hemoglobin, and screening for tuberculosis are required as part of the physical assessment.

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Urine Analysis: Result: Negative Date: 06/29/2018
Haemoglobin: Result: 138g/L Date: 06/29/2018

Weight 43kg Height 164cm Blood Pressure A Pulse 67

Visual Acuity: uncorrected Right 1.0 Left 0.5
corrected Right 1.0 Left 1.0

Please circle if the student wears ✓glasses or contact lenses.
Please provide a copy of the eyewear prescription.

System	Check Here If Normal	Comments on abnormalities
Ears, nose, throat	Normal	
Cardiovascular	Normal	
Respiratory	Normal	
Gastrointestinal	Normal	
Genito-urinary	Normal	
Neurological	Normal	
Musculoskeletal	Normal	
Breast and lymphatic	Normal	
Skin	Normal	

Have you any concerns about the student's health that should be followed up while in attendance at the College? Yes ☐ No ☑
If yes, please specify: _____
_____

Restrictions, if any: _____
_____

Except as noted above, this student is in satisfactory mental and physical health and should be able to participate in a full academic and physical program.

Chen Peiqin 6/29/2018
Signature of Medical Examiner Date

Medical examiner's full name CHEN PEIQIN

Medical examiner's office address: NO.738 Changjiang Rd. Suzhou City, P.R.China

Telephone: +86 51266656350 Fax: _____ Email: _____