**Declaration on Food Restrictions**

Thank you for applying to the ISI Winter Program. We may provide food to participants at times during the course, so we would like to know if you have any allergies or dietary restrictions. We would appreciate it if you could understand that, unfortunately, it is not possible for us to keep track of all the students’ diets, so students must take care when eating.

**Question 1：Do you have a food allergy?**

No ⇒　Question 2　　　　　　　Yes ⇒　　Please tick all that apply.

|  |  |
| --- | --- |
| Food Group | Details |
| Eggs | Chicken Eggs　 Fish Eggs/Caviar　  Other (　　　　　　　 　　　　　　　　　　 　） |
| Dairy | Milk　　 Butter　 Cheese　 Dairy Cream　 Anything that contains dairy  Other（　　 　　　　 　　　　） |
| Grains | Wheat　 Soba　  Other（　　　　　　　　　　　　　　　　　　　　　　　　　 ） |
| Nuts and Beans | Soy Beans　 Peanuts　 Almonds　 Walnuts  Other （　　　　　　　　　　　　　　　　　　　　 　） |
| Crustacean and Shellfish | Shrimp　 Crab　 Squid/Calamari　 Shellfish（ ）  Other（　　　　　　　　　　　　　　　 　　　　 　 ） |
| Fish | Fish in General　 Bluefish　 River Fish  Other （　 　　　　　　　　　　　　　　） |
| Meat | Beef　 Pork　 Chicken　 Duck　 Lamb  Other（　　　　　　　　 　　　　　　　　　　　　　　　　　） |
| Fruit | Peach　 Apple　 Banana　 Kiwi　 Mango  Other（　　　　　　　 　　　　　　　　　　　　　　　　　） |
| Other | Enter here: ( ) |
| Allergy Symptom Details | Mild symptoms  Severe symptoms, doctor recommends against it  Extract or essences are acceptable  Other（　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　） |

**Question 2：Are you vegetarian?**

No ⇒　Question 3 　Yes ⇒　Please tick all that apply.

|  |  |
| --- | --- |
|  | Type |
|  | 1. Semi-Vegetarian |
|  | 1. White Meat Vegetarian |
|  | 1. Non-Meat Eater |
|  | 1. Pesco Vegetarian (pescetarian) |
|  | 1. Lacto-Ovo Vegetarian |
|  | 1. Vegan |
|  | 1. Fruitarian |
|  | 1. Other |

**Question 3: Do you have any religious dietary restrictions?**

Yes ⇒　Please tick all that apply　　　No ⇒　Question 4

|  |  |
| --- | --- |
|  | Religion |
|  | 1. Hinduism |
|  | 1. Islam/Muslim |
|  | 1. Judaism |

**Question 4:** If you have any other information you’d like to add about your diet, please write it in the box below.

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**Declaration on Health Status**

Please use this declaration form to provide information regarding your current health status.

To lead healthy lives for all students, it is important for faculty members to be aware of your health condition. Please fill in the following sections in detail.

Please acknowledge that we do not provide medical practice or dispense medication at school. This declaration will be kept confidential.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. How is your current health condition?   Please select from the following options. | | | Very good  Normal  Not good　 　　 Bad | | |
| 1. Are you currently undergoing treatment for any health issues? | | | No  Yes | From YYYY/ MM/  Name of disease（　　　　　　　　　　　　　　　 　 　） | |
| 1. Are you currently taking any medications?  \*Includes over-the-counter medications | | | No  Yes | Time of prescription　　　YYYY/ MM/  Medicine：　Tranquilizer　　Sleeping tablets  Antiepileptic drugs 　　　 Asthma medications  Others:（　　 　　 　 　） | |
| 1. Have you had any surgeries or been hospitalized in the past five years? | | | No  Yes | Time in hospital　　 　YYYY/ MM/  Reason（　　　　　　　　　　　　　　　　　　　　　　　　 　　） | |
| 1. Do you have a past history of diseases or any chronic diseases?   If so, please select from the following options, and fill out the checked sections in detail. | | | | | |
| 1. Tuberculosis infection | No  Yes | Onset  　YYYY/ MM/ | | Current status  　Recovered　　　　　　Taking medicine | |
| 1. Mental disorder | No  Yes | Onset  　YYYY/ MM/ | | Depression  Anxiety  Panic disorder  Insomnia  Attention deficit hyperactivity disorder（ADHD)  Other ( ) | |
| 1. Allergies   including asthma | No  Yes | Onset  　YYYY/ MM/ | | Food Medicine  Chemical products  Other（　　　　　　　　　　 　　　　 　　　　　　 ） | |
| 1. Malaria, or other　infectious diseases | No  Yes | Onset  　YYYY/ MM/ | | Name： | |
| 1. Diabetes | No  Yes | Onset  　YYYY/ MM/ | | Current situation  　Taking medication　　　 Insulin self-injection. | |
| 1. Epileptic or convulsive seizures | No  Yes | Onset  　YYYY/ MM/ | |  | |
| 1. Other | No  Yes | Onset  　YYYY/ MM/ | | Current Status  Recovered  Taking medicine | |
| 1. Do you have any vaccination history? | | BCG  M.M.R.  Polio  Measles  Rubella  Diphtheria  Tetanus  Meningitis　  Other（　　　 　　　　　　 ） | | | |
| 1. Special needs for dietary treatment or diet restriction | | No  Yes | | | From　 　YYYY/ MM/  Details （　　　　　　　　　　　　　　 　　　 ）  Reason（　　　　　　　　　　　　　　 　　 ） |
| 1. Please, write any other information regarding your health condition that the school should know in advance. | | | | | |

I declare that the above information is true and correct.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicant’s signature:** |  |  | **Date:** | **YYYY/ MM/ DD/** |