**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/**  |