



Business Name & Address :

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please check appropriate box

Guardian     Family Relative     Family Friend     Emergency Contact

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Fax: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Business Name & Address :

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please check appropriate box

Guardian     Family Relative     Family Friend     Emergency Contact

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Fax: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Business Name & Address :

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**What is your residential preference?**     Residence     Homestay

- Placements will be made according to availability and suitability.

**Homestay Preferences:**

Please Indicate your preferences with a check mark:

Family Type

Family with children     Family with teenagers     Family Adults     No Preference

Do you like pets in the home?

Dogs     Cats     No Pets     Doesn't matter

Would you like to Share a room?     Yes     No     Doesn't matter

When is your preferred study time?     Morning     Evening     Night

List Hobbies and Interests: \_\_\_\_\_

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Do you have a personal computer you would like to bring to your homestay?  Yes     No

Does it have Internet capabilities?  Yes     No

Are you willing to pay for internet services in the home?  Yes     No

**DIETARY**

*Dietary Preferences:*

- strictly vegan
- strictly ovo-lacto vegetarian
- prefer vegetarian but eat some meat
- strictly no red meat
- variety meats & vegetables
- Other \_\_\_\_\_

*Do you have any Diagnosed Food Sensitivities?*  Yes  No

List Foods: \_\_\_\_\_

Usual Reaction: \_\_\_\_\_  Mild  Moderate  Severe

Have you been prescribed any medications for your Sensitivity?  Yes  No

List Medications \_\_\_\_\_

Do you take any Nutritional Supplements or Naturopathic Remedies for your sensitivities?

Yes  No List them \_\_\_\_\_

*Do you have any Diagnosed Food Allergies?*  Yes  No

List Foods \_\_\_\_\_

Usual Reaction: \_\_\_\_\_  Mild  Moderate  Severe

Have you been prescribed Epinephrine for the Reaction?  Yes  No

If yes, do you have  auto-injector or  manual inject

Have you been prescribed any other medications for your allergy?  Yes  No

List Medications \_\_\_\_\_

Do you take any Nutritional Supplements or Naturopathic Remedies for your Allergies?

Yes  No List them \_\_\_\_\_

**HEALTH**

Do you smoke?  Yes, (How many per day ? \_\_\_\_\_ )  No

Are you aware of NCCI's regulations on smoking  Yes  No

Do you have any Health problems other than allergies? Details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you taking any medications other than those named previously?  Yes  No

List: \_\_\_\_\_

Do you have any Diagnosed Allergies other than food?  Yes  No

List \_\_\_\_\_  
 Usual Reaction: \_\_\_\_\_  Mild  Moderate  Severe  
 Have you been prescribed Epinephrine for the Reaction?  Yes  No  
 If yes, do you have  auto-injector or  manual inject  
 Have you been prescribed any other medications for your allergy?  Yes  No  
 List Medications \_\_\_\_\_  
 Do you take any Nutritional Supplements or Naturopathic Remedies for your Allergies?  
 Yes  No List them \_\_\_\_\_  
 \_\_\_\_\_

**Give Details of your Health Insurance:**

*Primary Insurance*  
 Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Expiry Date: \_\_\_\_\_  
*Secondary Insurance*  
 Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Expiry Date: \_\_\_\_\_

Do you have Insurance that covers purchasing medications?  yes  no  
 Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Expiry Date: \_\_\_\_\_  
 Do you have Dental Insurance?  yes  no Company \_\_\_\_\_  
 \_\_\_\_\_ Policy Number \_\_\_\_\_ Expiry  
 Date: \_\_\_\_\_

Please add any comments that you feel will help us match you with a Homestay family  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Return to : Ms. Nazli Golshan, NCCI Residential Co-ordinator  
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