

Part 2: Language Background and Educational Information.

Native language: _____

Check level of proficiency of non-native languages:

English language: excellent good fair minimal

Other: _____ excellent good fair minimal

Educational Background:

<u>Level</u>	<u>Name of School</u>	<u>Address</u>	<u>Dates of Attendance</u>
Primary			
Secondary			

Part 3: Supplemental Information.

Please answer the following questions to help us find a compatible host family.

1. Do you smoke? yes no

If you do, please realize that there are very strict smoking laws regarding smoking.

If you don't smoke, would it be difficult for you to live with a family that does? yes no

2. Religious affiliation, if any: _____

Is weekly attendance at your church essential desirable not important?

Would you go with your host family to church-related social activities even if the church is not the same as your own?

yes no

3. What are some of your favorite hobbies, sports and/or activities?

4. List three adjectives your classmates would use to describe you:

Part 4: Health Information

To be completed and signed by the candidate's physician. The physician should not be related to the candidate. Each question must be answered with a detailed explanation included or attached in a separate report for "Yes" responses to questions 2A-G, 5 and 6. Mt. Ararat Eagle Exchange Program reserves the right to ask for further information and determine if the candidate meets the program medical qualifications. The candidate and parent/guardian must also sign.

▲ Candidate Name _____ ▲ Country _____ ▲ Date of Birth _____

1. Height _____ Weight _____ B/P _____ Pulse _____ Resp _____

Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration?
 yes no If yes, explain:

2A. Has the candidate had the diseases/conditions listed below? (Check yes or no)

Measles.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	(if known: Titer _____ date _____)
Mumps.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	(if known: Titer _____ date _____)
Rubella.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	(if known: Titer _____ date _____)
Chicken Pox.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Poliomyelitis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Hepatitis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Tuberculosis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Rheumatic Fever.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Cough (persistent, recurring).....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Headaches (persistent, recurring).....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Sleepwalking.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Enuresis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Appendicitis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Parasites (intestinal).....	<input type="checkbox"/> yes	<input type="checkbox"/> no	

Please give detailed information and dates (use extra pages if necessary):

2B. ACNE yes no If yes, identify area, severity, any medication taken, name, dosage and frequency:

2C. ALLERGIES yes no If yes, identify type, any medication taken, name, dosage and frequency:

2D. ASTHMA yes no If yes, identify type and severity:

Identify any medication taken, name, dosage and frequency:

2E. DIABETES yes no If yes, identify type and severity:

Identify any medication taken, name, dosage and frequency:

2F. SEIZURE DISORDER yes no If yes, identify type and severity:

Identify any medication taken, name, dosage and frequency:

2G. Has the candidate ever had any disease, impairment or abnormality of

Abdominal organs, digestive system..... yes no

Lungs, respiratory system..... yes no

Bones, joints, locomotor system..... yes no

Genito-urinary system..... yes no

Heart or blood vessels..... yes no

Tonsils, nose or throat..... yes no

Blood, endocrine system..... yes no

Eyes/vision, ears/hearing..... yes no

If yes, please explain: (use extra pages if necessary)

3. Has the candidate been hospitalized? yes no If yes, give dates, diagnosis and outcome for each incident:

4. Is the candidate currently taking medication or injections ? (other than those mentioned previously) yes no

If yes, identify the medication, reason for usage, dosage and frequency:

5. Has the candidate EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder? yes no
 Is there a history of, or present evidence of, an emotional, nervous or eating disorder? yes no
 If yes to either, a FULL report by the specialist and a statement by the candidate about the illness or specific problem must be attached in a sealed envelope. Note: Placement in a foreign host family, school and community requires adjustment which often involves emotional stress. It will not be a time for relaxation or temporary relief from any current therapy. If the candidate is experiencing current emotional, physical, personal or family difficulties, these difficulties can be severely exacerbated by the adjustment demands of the program. Therefore, you are requested to evaluate carefully the candidate's current or previous condition and treatment along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment..

6. Are there any health limitations or restrictions on the candidate's activities and/or sports participation or any medical information which should be considered for a home/school placement? yes no If yes, please describe:

7. Does the candidate wear glasses or contact lenses? yes no

8. What was the date of the candidate's last dental check-up? _____

Does the candidate wear dental braces? yes no

If yes, will orthodontic care be needed while on the program? yes no Frequency? _____

9. Candidate has had the following immunizations, please specify exact day, month and year:

	Day/Mo/Yr	Day/Mo/Yr	Day/Mo/Yr	Day/Mo/Yr	Day/M/Yr
Measles	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Diphtheria	_____	_____	_____	_____	_____
Pertussis	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
Poliomyelitis	_____	_____	_____	_____	_____
BCG	_____	_____	_____	_____	_____
TB Test	Which type (circle one): Mantoux or Tine?		Date _____	Result (+/-) _____	
If positive, was chest x-ray done?			<input type="checkbox"/> yes <input type="checkbox"/> no	Result (+/-) _____	

Certification:

I, the undersigned, certify that a thorough physical examination of the candidate has been given and all important recent medical information has been included on the form, that nothing relevant has been omitted, and that the candidate is able to travel. I understand that the omission of any information could be harmful to the candidate's health care and could result in early termination from the Mt. Ararat Eagle Exchange Program.

▲ Physician Name and Degree ▲ Signature

▲ Address ▲ Date

Your signature below attests that you understand and accept the Mt. Ararat Eagle Exchange Medical Policies as stated on the Participation Agreement, that the information on the Health Certificate forms are complete and that inaccurate or incomplete information could be harmful to the candidate's health care and could result in early termination from the Mt. Ararat Eagle Exchange Program.

▲ Candidate Signature ▲ Date

▲ Parent/Legal Guardian Signature ▲ Date

Part 5: Written Response.

Please use this side of the application to write your response to the following questions:

Why would you like to spend a year in Maine? What do you hope to gain from this experience? How might this experience affect your future career or personal goals?

Part 6: Photo page.

Minimum one page

