Part II: Health Report and Examination

Dear Physician: It is of crucial importance that you give us your careful, candid, and complete evaluation of this applicant's health. The Experiment program involves a challenging exercise in cross-cultural adjustment that includes a period of living as an active, contributing member of a family abroad, plus several days to two weeks of travel . This applicant will be part of a group of 10 to 20 young people and an adult group leader. To succeed, this applicant must be able to adjust to varying changes in climate, diet and living conditions-sometimes under difficult circumstances- and have a high degree of motivation. **Part III of the Health Form is to be used for further health information** and is to be completed by a physician or treating professional. This information is strictly for the use of World Learning and The Experiment in International Living. This is a brief summary of the program and is not designed to be all-inclusive.

Please mail or fax immediately to: The Experiment-Student Health Office, PO Box 676, Kipling Road, Brattleboro, Vermont 05302 USA | Fax 802 258-3427

Participant's Name _____ **Program** _____

Date of physical examination *(must be given since June 1, 2016)* _____

Immunization Record

Indicate the most recent date. The following immunizations are the minimum **REQUIRED**. Check Heath Guidelines for other country-specific required and recommended immunizations. Attach record if available. If proof of immunity is by titer, attach copy of lab report.

Tetanus/diphtheria/pertussis (Td or Tdap) _____ / _____ /

Measles, Mumps, Rubella (MMR #1) _____ / _____ /____

Measles, Mumps, Rubella (MMR #2) _____ / _____ /____

Other Immunizations:

_____ _____ / _____ /____

_____ _____ / _____ /____

Height _____

Weight _____

REQUIRED (for certain programs): This test must be performed within one year prior to program start date.

TB test Date_____ / _____ / _____ **TB Result** ☐ Negative ☐ Positive **(If positive, X-ray result required.)**

Please answer ALL questions.

1. Is this applicant seriously underweight or overweight?		☐ yes	☐ no
2. Is there a history of any eating disorder, such as bulimia or anorexia, within the last two years?		☐ yes	☐ no
3. Does this applicant have any allergies (including allergies to medication and/or food)?		☐ yes	☐ no
4. If applicant has allergies, is there a history of asthma, anaphylaxis, and other dangerous allergic conditions?	☐ n/a	☐ yes	☐ no
5. Is this applicant currently under medical treatment or taking medication?		☐ yes	☐ no
6. Does this applicant have any speech, hearing, eyesight, or physical impairment?		☐ yes	☐ no
7. If answer to Question 6 is yes, would this applicant have difficulties participating in an academically challenging and rigorous summer abroad program?	☐ n/a	☐ yes	☐ no
8. Has the applicant received counseling or mental health treatment within the last two years? (If "yes," permission will be asked of the applicant for a confidential report from the treating professional.)		☐ yes	☐ no
9. Is there any congenital or chronic condition that may require additional treatment?		☐ yes	☐ no
10. Would carrying luggage, or conducting strenuous travel, cause the applicant hardship?		☐ yes	☐ no
11. Are there limitations to physical activity? If yes, give details below.		☐ yes	☐ no

Please give details on any questions to which you have answered yes or on any points of concern in your examination or in this applicant's personal health history in Part I. Part III is to be used for further health information.

Having examined this applicant and reviewed his/her past medical history, I agree that the applicant is healthy enough to participate in the 20___ program indicated above.

Physicans signature _____ **Date** _____

Physicians Name (print) _____ **Telephone** _____
include are code or country and city codes

Physician's address _____ **Fax** _____
include are code or country and city codes

_____
city state zipcode

Participant's Name _____

Program _____

The EXPERIMENT in International Living

A PROGRAM OF WORLD LEARNING

Part III A: Further Health Information for Overseas Travel: Medical

To the Appropriate Medical Professional:

Studying abroad can be an enriching experience as well as a physically and mentally challenging one. Mild or pre-existing health conditions can become serious for some participants as they transition into an unfamiliar culture and environment. For this reason, we encourage all participants to fully disclose their health history so that we can prepare them properly for their experience, make arrangements for any special accommodations if necessary, and in some cases, assess whether there may be any health reasons that an applicant should consider another program.

In order to ensure the applicant's well being, we expect full disclosure of any health history that could be potentially problematic for a student overseas. Please give as much detail as possible in answering the following questions.

Please mail or fax immediately to:
EIL – Student Health Office, PO Box 676, Kipling Road, Brattleboro, Vermont 05302-0676 USA | Fax 802 258-3427

Please include appropriate relevant medical records and any information necessary for medical personnel overseas who might be treating this student.

1. Describe, in as much detail as possible, the relevant health condition.
   (For allergies, please indicate what this applicant is allergic to, how he or she reacts to it, and any medications that should be used by the applicant overseas.)

2. When did the applicant experience this condition, how did it occur, and when was the applicant diagnosed? (Give specific dates.)

3. How was this condition treated and for how long? (Give specific dates, medications, etc.)

Participant's Name _____

Program _____

The EXPERIMENT in International Living
A PROGRAM OF WORLD LEARNING

Part III A: Further Health Information for Overseas Travel: Medical (continued)

4. Are there currently any problems or issues of concern regarding this condition? (Describe plans for testing or treatment.)

5. What is the prescribed plan in the event that this health condition becomes an acute emergency overseas?

6. What are the limitations, if any, on this applicant's participation in an extremely rigorous (emotionally and physically) overseas program?

Medical Professional's Authorization

I, _____ (name of medical or treating professional), consider that _____ (name of applicant)

is fit to participate in _____ (country) in _____ (program) during summer 20_____ ,

and will send along with said applicant any medical records needed for possible treatment by a physician or medical facility abroad. Having received permission from said applicant, I am willing to further discuss problems pertaining to this issue with the professional staff of World Learning.

Signature of medical or treating professional _____ Date _____ (month/day/year)

Mailing address _____

_____
city state postal code country

Telephone _____
area code or country and city codes

Fax _____
area code or country and city codes

Participant's Name _____

Program _____

The EXPERIMENT in International Living

A PROGRAM OF WORLD LEARNING

Part III B: Further Health Information for Overseas Travel: Counseling & Mental Health

To the Appropriate Mental Health Professional:

Studying abroad can be an enriching experience as well as a physically and mentally challenging one. Mild or pre-existing health conditions can become serious for some participants as they transition into an unfamiliar culture and environment. For this reason, we encourage all applicants to fully disclose their health history so that we can prepare them properly for their experience, make arrangements for any special accommodations if necessary, and in some cases, assess whether there may be any health reasons that an applicant should consider another program.

In order to ensure the applicant's well being, we expect full disclosure of any health history that could be potentially problematic for a student overseas. Please give as much detail as possible in answering the following questions.

Please mail or fax immediately to:
EIL – Student Health Office, PO Box 676, Kipling Road, Brattleboro, Vermont 05302 USA | Fax 802 258-3427

Please include appropriate relevant medical records and any information necessary for medical personnel overseas who might be treating this student. Please use additional paper if necessary.

1. Describe, in as much detail as possible, the relevant mental health condition and/or precipitating event(s) that led the applicant to seek counseling. State DSM-5 diagnosis(es) if applicable; please list the applicant's specific symptoms.

2. When did the applicant experience this condition, and when was the applicant diagnosed? Please list specific dates.

3. How was this condition treated and for how long? Include dates and type of treatment, name and dosage of medication(s) etc.

4. Describe any triggers that might lead to the recurrence of symptoms.

Participant's Name _____

Program _____

The EXPERIMENT in International Living
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Part III B: Further Health Information for Overseas Travel: Counseling & Mental Health (continued)

5. List specific coping strategies that this applicant has used for this condition and other stressful situations.

6. Are there any current problems or concerns regarding this condition? If so, please explain, along with any recommendations.

7. What is the prescribed plan in the event that this condition becomes an acute emergency overseas?

8. What are the limitations, if any, on this applicant's participation in an extremely rigorous (emotionally and physically) overseas program?

Mental Health Professional's Authorization

I, _____, consider that _____
name of medical or treating professional — name of applicant

is fit to participate in _____ in _____ during summer 20_____ , and will send along with said applicant
country — program

any medical records needed for possible treatment by a physician or medical facility abroad. Having received permission from said applicant, I am willing to further discuss problems pertaining to this issue with the professional staff of The Experiment in International Living.

Signature of medical or treating professional _____ Date _____
month/day/year

License _____ Title _____

Mailing address _____

_____
city — state — postal code — country

Telephone _____ Fax _____
area code or country and city codes — area code or country and city codes