



HEALTH FORM INSTRUCTIONS

1 Kipling Road, PO Box 676
Brattleboro, Vermont 05302
P: 800.345.2929
F: 802.258.3427

1015 15th Street NW, 9th Floor
Washington, DC 20005
P: 202.408.5420
F: 202.408.5397

info@experiment.org
experiment.org

The Personal Health History form (Part I) is required to confirm participation once an Experimenter has been offered admission or has pre-registered.

The Health Report & Examination form (Part II) and any requested Supplemental Health Forms (IIIA/IIIB) must be completed within 4-6 weeks of admission confirmation. Please schedule a physical appointment as early as possible. If this is not possible, then please let us know the date of your doctor's appointment for the completion of Part II.

Only The Experiment in International Living health form will be accepted. Other health forms (school, sports physical exam, etc.) cannot be accepted.

Please upload Part I to The Experiment Portal and email Part II and IIIA/IIIB if applicable, to medicalteam@experiment.org.

The guidelines below will assist you in completing your health form. Please be advised that leaving anything blank on your health form will delay your health clearance. Your health form will not be reviewed until all completed parts are received. Complete name and program at the top of all pages. Only The Experiment health forms will be accepted.

Please be sure to make a copy of the completed health form for your records.

PART I: Personal Health History

- REQUIRED FOR ALL EXPERIMENTERS
- To be completed by Experimenter's custodial parent or legal guardian with The Experimenter.
- Immunization history is to be recorded in Part I. These records can usually be obtained from your physician's office or school.
- Please print a copy of Part I and take it to the medical provider who completes Part II (Health Report and Examination).

PART II: Health Report and Examination

- REQUIRED FOR ALL EXPERIMENTERS
- The information on Part II must be based on a complete physical examination conducted within 12 months of your program's start date.
- We will accept only health reports that have been completed and signed by a primary care health professional (MD, DO, Nurse Practitioner, Physician's Assistant) who is not related to the Experimenter.

PART III: Supplemental Health Form

PART IIIA - Further Health Information

- To be completed by The Experimenter's applicable medical specialist if requested by The Experiment Medical Consultants.

PART IIIB - Counseling & Mental Health

- To be completed by The Experimenter's applicable mental health/behavioral specialist who have provided services to the Experimenter if requested by The Experiment Medical Consultants.

Please review the CDC recommendations of each country that you will be studying abroad with the Experiment and see a travel doctor for recommendations on immunizations, vaccines & prophylaxis. It is helpful to print your health guidelines & carry it with you to your appointment so you may review information with your healthcare provider. **Malaria prophylaxis** should be considered for the countries with identified malaria risk.

CHANGE OF STATUS: You are responsible for notifying The Experiment immediately of any changes in your health history prior to your departure or while on the program.



HEALTH FORM AUTHORIZATION

1 Kipling Road, PO Box 676 1015 15th Street NW, 9th Floor info@experiment.org
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AUTHORIZATION AND PERSONAL HEALTH HISTORY

The Authorization and Personal Health History form must be submitted within TWO WEEKS of your offer of admission. Answer ALL questions and submit with the rest of your confirmation materials.

Full disclosure is encouraged so we can prepare you properly for your Experiment **abroad program experience**, make any necessary special arrangements, and in some cases assess whether an Experimenter should consider another program based on availability of program resources and/or access to medical or psychological treatment services.

A summary of your health history will be **provided to your program staff** support medical conditions and facilitate emergency healthcare. This information will be kept confidential. A member of The Experiment staff may contact you to discuss program realities and to clarify expectations. Please note that failure to disclose complete and accurate information on the health form may result in dismissal from the program. **The Experiment health clearance is a mandatory requirement for participation in ALL The Experiment programs.**

Students seeking accommodations are asked to contact Disability Services at disabilityservices@experiment.org.

Please complete and sign the following:

As an applicant to an Experiment program, I, hereby authorize the physician or medical provider who has provided information to The Experiment in connection with my application or participation in the Program, to release any or all health records or information pertaining to me to The Experiment. I also authorize the release by The Experiment of my health records or other medical information pertaining to me to my parent or other designated contact person in the event of an emergency.

I also agree that if I submit a formal request for accommodations to The Experiment Disability Services, The Experiment may share the information in my health record with Disability Services to help in determining my eligibility for accommodations.

Experimenter Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

(if Experimenter is under 18)



PERSONAL HEALTH HISTORY

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Experimenter Name: _____

Experimenter DOB: _____

Program Name: _____

Part I: Personal Health History

Please check if your Experimenter has experienced any of these diagnoses or symptoms. Please provide as much detail as possible on any checked response or other concern.

Immunization Record

Immunizations listed below are the minimum **recommended**.

Check The Experiment program health guidelines and CDC for other country-specific required and recommended immunizations. <https://wwwnc.cdc.gov/travel/destinations/list>

Have you received?

*Measles, Mumps, Rubella (MMR #1)

Yes No

*Measles, Mumps, Rubella (MMR #2)

Yes No

*Tetanus/diphtheria/pertussis (Td or Tdap)

Yes No

*Meningitis

Yes No

*Covid 19

Yes No

Allergy (please specify below)

*Environmental allergies (pet/animal dander, bees)

Yes No

*Food allergies (nuts, eggs, shellfish)

Yes No

*Medication allergies (penicillin, sulfa)

Yes No

*Other Allergy

Yes No

If yes, list other allergy here: _____

If you checked yes for any type of allergy above please answer the following:

List specific allergens: _____

What symptoms do you experience when exposed?

What is the treatment?

The Experiment requires all students with potential anaphylactic allergic reactions to bring at least two epi-pens or more with them to their program.

I have read and understand this Experiment policy.



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Medical History

Please include additional details as requested for any questions in which you have answered Yes.

1. Severe headaches

Yes No

If Yes - Please tell us more. How do you manage your condition? When was your most recent migraine (yesterday, last month)? How frequent are your migraines? How debilitating?

2. Epilepsy (seizures)

Yes No

If Yes - Please tell us more. When was your last seizure? How do you manage your condition?

3. Head injury/concussion

Yes No

If Yes - Please tell us more. When were you diagnosed? Does your concussion or head trauma still impact you? If so, please explain how.

4. Eye problems (excluding need for glasses or contacts)

Yes No

If Yes - Please tell us more. How do you manage your condition?

5. Hearing impairment

Yes No

If Yes - Please tell us more. How do you manage your condition?

6. Asthma

Yes No

If Yes - Please tell us more. When were you diagnosed (childhood, college, year)? What diagnosis do you have (mild, chronic, exercise-induced, viral or cold induced, etc.)? When was your last episode or attack (yesterday, ten years ago)? How do you manage your condition? What is the treatment plan in the case of a flare up while abroad?

7. Diabetes

Yes No

If Yes - Please specify diagnosis (type I, type II diabetes) and provide details, including date of diagnosis, and how you manage you diabetes? Do you require access to refrigeration for medications?

8. Endocrine disorder (thyroid etc.)

Yes No

If Yes - Please tell us more. How do you manage your condition?

9. Heart disease

Yes No

If Yes - Please tell us more. When were you diagnosed? How do you manage your condition?

Comment below on any condition(s) that you have checked above:



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10. High blood pressure

Yes No

If Yes - Please tell us more. How do you manage your condition?

11. Gastrointestinal problems (abdominal concerns, celiac disease)

Yes No

If Yes - Please tell us more. How do you manage your condition?

12. Bladder/kidney problems

Yes No

If Yes - Please tell us more. How do you manage your condition?

13. Back or joint problems that require treatment or limit your mobility

Yes No

If Yes - Please tell us more. How do you manage your condition?

14. Immune system problems

Yes No

If Yes - Please tell us more. How do you manage your condition?

15. Blood disorder (bleeding, anemia, clotting)

Yes No

If Yes - Please tell us more. How do you manage your condition?

16. Cancer

Yes No

If Yes - Please tell us more. When were you diagnosed? How do you manage your condition?

17. HIV

Yes No

If Yes - Please tell us more. When were you diagnosed? How do you manage your condition?

18. Hepatitis B or C

Yes No

If Yes - Please tell us more. When were you diagnosed? How do you manage your condition?

19. Do you use a medical device or equipment?

Yes No

If Yes - Please tell us more

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20. Do you have any medically necessary dietary requirements?

Yes No

If Yes - Please tell us more

21. Are you currently pregnant?

Yes No

If Yes - When is your expected due date?

Mental Health History

22. Attention Deficit Disorder/Attention Deficit Hyperactive Disorder (ADD/ADHD)

Yes No

If Yes - Please specify diagnosis and provide details, including date of diagnosis and how your ADD/ADHD is managed.

23. Autism Spectrum Disorder (ASD)

Yes No

If Yes - Please specify diagnosis and provide details, including date of diagnosis, and how your ASD is managed. Please list triggers and coping mechanisms and anything else you'd like us to know.

24. Bipolar disorder

Yes No

If Yes - Please specify diagnosis and provide details, including date of diagnosis, and how your bipolar disorder is managed. Please list triggers and coping mechanisms and anything else you'd like us to know.

25. Depression

Yes No

If Yes - Please specify diagnosis and provide details, including date of diagnosis, and how your depression is managed. Please list triggers and coping mechanisms and anything else you'd like us to know.

26. Anxiety

Yes No

If Yes - Please specify diagnosis and provide details, including date of diagnosis, and how your anxiety is managed. Please list triggers and coping mechanisms and anything else you'd like us to know.

27. Frequent suicidal thoughts/past suicide attempt(s)

Yes No

If Yes - Please provide details about any frequent suicidal thoughts and/or past suicide attempt(s), including dates and mental health support you have received. Please list triggers and coping mechanisms and anything else you'd like us to know.

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28. Self-Harm

Yes No

If Yes - Please provide details about past and/or current self-harm including how long you engaged in self-harm behaviors and mental health support you have received. Please list triggers and coping mechanisms and anything else you'd like us to know.

29. Eating disorder

Yes No

If Yes - Please specify diagnosis (anorexia, bulimia, binge eating disorder, or other) and provide details, including date of diagnosis, if you ever received intensive or outpatient treatment and how your eating disorder is managed. Please list triggers and coping mechanisms and anything else you'd like us to know.

30. Substance Abuse

Yes No

If Yes - Please provide details of any treatment for substance abuse you have received including that which was court-mandated. Please list triggers and coping mechanisms and anything else you'd like us to know.

31. Addiction

Yes No

If Yes - Please specify the diagnosis, and provide details, including date of diagnosis, if you ever received in-patient or out-patient treatment, and how your addiction history is managed. Please list triggers and coping mechanisms and anything else you'd like us to know.

32. Other Mental Health Issues

Yes No

If Yes - Please share details including date of any diagnosis and any mental health support you have received for this issue. Please list triggers and coping mechanisms and anything else you'd like us to know.

Please provide details on the following:

33. Are you currently taking any medications for any health conditions checked above (including antigen/immunotherapy injections, asthma medications, antidepressants, anti-anxiety meds, etc.)?

Yes No

If Yes - please list name of medication including dose, when it is to be taken & how long you have been taking this medication.

34. Have you ever been hospitalized?

Yes No

If Yes - please list dates and reason for hospitalization

35. Do you have any permanent injury or physical disability?

Yes No

If Yes - Please tell us more

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36. In the last two years, have you consulted or been treated for a mental health condition, suicidal thoughts or self-harm, substance/alcohol abuse, or eating disorder?

Yes No

If Yes - Please share details including date of any diagnosis and any mental health support you have received for this issue. Please list triggers and coping mechanisms and anything else you'd like us to know.

Required for all Experimenters: Please describe how you plan to maintain your emotional and physical health and well-being while on this program.

Comment below on any condition(s) that you have checked above:

I hereby verify that all of the information contained in this form is accurate and complete and acknowledge that any failure to provide accurate and complete information, including notification to The Experiment of changes in my health affecting the accuracy or completeness of the information contained in this form, may result in my dismissal from the program. I agree to notify The Experiment of any material changes in my health that occur prior to the start of the program or while on the program.

*With my signature below, I certify that the information above is accurate and complete.

Experimenter Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

(if Experimenter is under 18)

The Experiment has a Disability Services office. Students who would like information about the disability accommodation process should contact disabilityservices@experiment.org

I have read and acknowledge the above information.



WELLNESS ACKNOWLEDGMENT

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Program Name: _____

Wellness Acknowledgement

As an Experimenter, I acknowledge that I am expected to:

1. Accept responsibility for my physical and mental health, *to include fulfilling self-care strategies and medication routines recommended by medical/mental health providers*
2. Effectively communicate with The Experiment staff if experiencing distress and/or needing assistance
3. Seek consultation with medical/mental health providers, as needed/referred, and follow their treatment advice
4. Practice self-care techniques and de-stressing activities, *which often include exercise, proper sleep routines, healthy eating/hydration, abstaining from alcohol, journaling, mediation, yoga, deep breathing, maintaining appropriate peer interactions and contact with people in my support system, etc.*
5. Generally, sustain a disposition that:
 - Accepts that new situations and locations may generate significant levels of ambiguity and ambivalence
 - Remains adaptable to required scheduling and location changes
 - Recognizes that the needs of the group often transcend the desires of any one individual
 - Exercises sound judgment in the absence of direct supervision
 - Maintains a reasonable level of situational awareness appropriate to circumstances

When Experimenters fall short of these expectations, The Experiment may develop an individualized wellness agreement with the student that expresses specific expectations moving forward, as well as consequences if not observed.

With my signature below, I certify that the information above is accurate and complete.

Experimenter Signature _____ Date _____

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NEXT STEPS

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Participation in an Experiment program is contingent upon review of the Experimenters completed health forms.

NEXT STEPS

Part II: Health Report and Examination

The Health Report and Examination is based upon a physical examination conducted within 12 months of your program's start date. To be completed and signed by your health care provider (physician, nurse practitioner, or physician's assistant).

Please note: We do not accept reports completed by a health care provider who is related to you.

Also, if you answered yes to the above questions in the Personal Health History section and have received medical and /or mental health treatment, please schedule appointments **immediately** with your medical and mental health providers to complete the supplemental health forms below. Once the supplemental health forms have been completed email them to medicalteam@experiment.org.

Part IIIA: Further Health Information: Medical

If you answered "yes" to any questions indicating a history of medical treatment, please have your medical professional complete the Further Health Information: Medical form.

Part IIIB: Further Health Information: Counseling and Mental Health

If you answered "yes" to any questions indicating a history of therapeutic treatment, please have your mental health professional complete the Counseling and Mental Health Form of this packet.

The Experiment health form(s) must be completed within 4-6 weeks of admission confirmation.

Please initial here to acknowledge you have read the above statements.

PARTICIPANT
INITIALS

PARENT/GUARDIAN
INITIALS