The EXPERIMENT in International Living

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
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info@experiment.org
experiment.org

PART IIIB

Experimenter Name: _____

Experimenter DOB: _____

Program Name: _____

Part IIIB: Further Health Information: Counseling and Mental Health

To the Appropriate Mental Health Professional:

Studying abroad is an enriching experience as well as a physically, mentally, and emotionally challenging one. Mild or resolved (pre-existing) health conditions may become serious or recur for some Experimenters as they transition into unfamiliar cultures and environments. For this reason, we encourage all Experimenters to fully disclose their health history so we can help them prepare for their experience, make arrangements for any special accommodations if necessary, and—in some cases—assess whether health considerations pose great enough risk that an Experimenter should consider another program. Failure to disclose complete and accurate information on these health forms or failure to inform The Experiment of any changes in health history or status that occur after the submission of these health forms may result in an inability to meet accommodation requests or in dismissal from the program.

The Experiment programs are not therapeutic programs and while our field staff are well-trained, they are not mental health professionals. For this reason, we expect students to effectively communicate to staff if they are experiencing distress or need assistance and manage their stress levels by practicing good self-care.

To support this Experimenter's health and wellness, we expect complete disclosure of any health history &/or concerns that could be experienced (problematic) overseas. Please give as much detail as possible in answering the following questions.

1. Review student-reported medical information (Part I) and verify completeness & accuracy.
2. Provide a detailed summary of counseling or mental health issues for which you provide care for the student. You may also include a consultation summary.
3. Recommend for or against participation.

This information is strictly for the use of World Learning and The Experiment in International Living and will not be released without the applicant's consent.

The forms may be emailed by the Experimenter or your office to medicalteam@experiment.org.

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.

_____

_____

When did this adolescent experience this condition? When were they diagnosed and by whom? (Please provide specific dates and timelines)

_____

_____

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

Describe any conditions or triggers that may lead to the recurrence of symptoms for this adolescent:

_____

_____

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List specific coping strategies that this adolescent has used for this condition and/or other stressful situations:

_____

_____

Are there any current concerns regarding this condition? If so, please explain and include details of how these concerns will be addressed before the Experimenter departs for program:

_____

_____

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

_____

_____

Ongoing treatment that is anticipated to continue during the program:

_____

_____

Risk of this condition needing **additional** care during program: ☐High ☐Medium ☐Low

What might this care consist of?

_____

_____

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

_____

_____

How do you anticipate this adolescent responding to the experience of traveling, including the experience of living with a local family in a homestay?

_____

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Licensed Mental Health Professional's Recommendation

Please check one of the following:

- ☐ **Experimenter is able to participate fully with no reservations.**
- ☐ **Experimenter may be able to participate, but with some difficulty or caveats.**
  (Please ensure your concerns, including specific reasons, are detailed in the summary above)
- ☐ **Participation is not recommended.**
  (Please ensure your concerns, including specific reasons, are detailed in the summary above)
- ☐ **Having received permission from said Experimenter, I am willing to further discuss problems pertaining to this issue with the professional staff of The Experiment.**

Provider Information

Thank you for providing a clear, honest, & concise assessment of this Experimenter's health status.

Physician's or health care provider's signature_____ Date _____
month/day/year

Name of practice_____ Phone_____
Include area code/country & city codes

Printed name_____ Email_____