HEALTH FORM INSTRUCTIONS

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P: 800.345.2929
F: 802.258.3427

1015 15th Street NW, 9th Floor
Washington, DC 20005
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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.

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HEALTH FORM AUTHORIZATION

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)

The EXPERIMENT in International Living

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 heath 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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PERSONAL HEALTH HISTORY

Experimenter Name: _____

Program Name: _____

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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PERSONAL HEALTH HISTORY

Experimenter Name: _____

Program Name: _____

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

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

_____

_____

_____

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PERSONAL HEALTH HISTORY

Experimenter Name: _____

Program Name: _____

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?

22. Daily/regular use of marijuana, alcohol or other psychoactive substance.
☐ **Yes** ☐ **No**

If yes - please provide details on what you use, how often & how much.

Please note that if you regularly use alcohol, marijuana or other psychoactive substances, it is common to experience significant withdrawal effects including anxiety, difficulty concentrating, difficulty sleeping and more serious symptoms that may impact your ability to be successful in your program.

The Experiment prohibits drug use, even for medical purposes, and you could experience withdrawals while on program.

Please be aware that The Experiment expressly prohibits the unlawful manufacture, distribution, possession, or use of any controlled substance by students or staff. Convincing indication of drug use requires immediate dismissal from any Experiment program. Medical marijuana use is not permitted.

It is recommended that you read our Experimenter handbook prior to departure. This outlines our policies and procedures including that of Alcohol and Other Drug Use.

23. Other Medical Condition
☐ **Yes** ☐ **No**

If yes- please tell us more- how do you manage your condition?

Mental Health History

24. 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.

25. 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.

26. 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.

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

_____

_____

_____

_____

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PERSONAL HEALTH HISTORY

Experimenter Name: _____

Program Name: _____

27. 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.

28. 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.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

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

_____

_____

_____

_____

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PERSONAL HEALTH HISTORY

Experimenter Name: _____

Experimenter DOB: _____

Program Name: _____

Please provide details on the following:

35. 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.

36. Have you ever been hospitalized?

☐ **Yes** ☐ **No**

If Yes – please list dates and reason for hospitalization

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

☐ **Yes** ☐ **No**

If Yes – Please tell us more

38. 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

Experimenter Name: _____

Program Name: _____

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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 _____

Parent/Guardian Signature _____ Date _____

(if Experimenter is under 18)

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

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Experimenter Name: _____

Program Name: _____

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

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HEALTH REPORT & EXAM

Experimenter Name: _____

Experimenter DOB: _____

Program Name: _____

Part II: Health Report and Examination

To the Examining Provider: It is of crucial importance that you give us your careful, candid, and complete evaluation of this adolescent'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 homestay family, and rigorous travel in all parts of the world, including remote areas of Africa, Asia, and Latin America that are sometimes without modern amenities. This adolescent will be part of a group of 10-20 peers and 2 adult group leaders. To succeed, this adolescent must have a high degree of motivation and must be prepared to adjust to changes in climate, diet, living conditions, and activity level—sometimes under challenging circumstances. Many will live with a family for a protracted period of time in varying conditions of sanitation and proximity to Western-style health facilities and psychological services. For these reasons you are asked to carefully consider the applicant's general fitness as well as physical and mental health in relation to the country, the type of program, and the conditions in which the applicant will be living.

Part III of the Health Form is to be used for further health information and is to be completed by the relevant treating provider.

Helpful Tips as You Complete This Form

- Review Part I (student-reported Personal Health History) & verify completeness & accuracy.
- Summarize medical & mental health issues below.
- Provide basic health evaluation.
- Review participant's itinerary & immunization/vaccination requirements. (See accompanying information.)
- 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.

Summary of Health Issues

This list should explain all medications the participant is currently taking and/or bringing with them.

Allergies: _____

Diagnosis	Name of Medication	Recommended plan if condition worsens

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HEALTH REPORT & EXAM

Experimenter Name: _____

Program Name: _____

Basic Physical Examination

Height:	
Weight:	
BMI (Body Mass Index):	
Blood Pressure:	
Pregnancy Test (if indicated):	☐ Positive ☐ Negative
HgbA1c (if diabetic):	

Any notable abnormal physical exam findings:

_____

_____

_____

Please review the CDC Recommendations (wwwnc.cdc.gov/travel/destinations/list) of each country the Experimenter will be visiting and provide recommendation on immunizations, vaccines, & prophylaxis. **Malaria prophylaxis** should be considered for the countries on the itinerary with identified malaria risk.

If Experimenter is currently under the care of a medical specialist, the Further Health Information medical form (Part IIIA) must be completed by that provider if requested.

If Experimenter is currently under the care of a mental health provider or counselor, the Counseling & Mental Health form (Part IIIB) must be completed by each mental health provider if requested.

Licensed Medical 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)

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_____

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PART IIIA

Experimenter Name: _____

Experimenter DOB: _____

Program Name: _____

Part IIIA: Further Health Information: Medical

To the Appropriate Healthcare 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 require 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.

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 medical 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.

Diagnosis:

_____

_____

Recent History of Illness:

_____

_____

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?

_____

_____

List any limitations, reservations, or other comments, to include recommendations if condition worsens:

_____

_____

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PART IIIA

Experimenter Name: _____

Program Name: _____

Licensed Medical 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_____

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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:

_____

_____

The EXPERIMENT in International Living

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Brattleboro, Vermont 05302
P: 800.345.2929
F: 802.258.3427

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Washington, DC 20005
P: 202.408.5420
F: 202.408.5397

info@experiment.org
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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.

Mental Health Professional's signature_____ Date _____
month/day/year

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

Printed name_____ Email_____

Specialty_____