



Candidate Application

PERSONAL

First name	Middle name	Last name	Birthdate
Home city	Home state / province	Home country	Sending organization

FOR OFFICE USE ONLY

ID#	Program applying for	Application status
Chapter	Region	Program Duration Preferences



AFS JENESYS Program Application Form

This will be sent to your host family.

Tell us about yourself: Introduce yourself (I.E, how you see yourself, your personality, your relationship with your family and friends, your responsibilities at home and at your school, list your favorites, interests and hobbies, and indicate how often you pursue them. Etc..)

Tell us about your family:

Tell us about your expectations for the program:

Tell us about your goals or plans which are important to you:

Name in Print:

Signature:

Date(day/month/year):

/ /



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 3-9, 11-13. AFS 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.

(Ms.) (Mr.) Candidate Name (First/Middle/Last) Home Country Birthdate

1 Height _____ Weight _____ B/P _____ Pulse _____ Respiration _____ Blood Type _____

2 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 _____

3 CHECK YES OR NO. HAS THE CANDIDATE HAD THE DISEASES / CONDITIONS LISTED BELOW:

Table with columns: Disease/Condition, YES, NO, IF KNOWN: (Titer, Date, or month/year), YES, NO. Rows include Measles, Mumps, Rubella, Chicken Pox, Poliomyelitis, Hepatitis, Tuberculosis, Rheumatic Fever, Cough, Headaches, Sleepwalking, Enuresis, Appendicitis, Parasites.

If yes, give detailed information and dates (use extra pages if necessary): _____

4 ACNE Yes No If yes, identify area, severity, any medication taken, name, dosage & frequency: _____

5 ALLERGIES Yes No If yes, identify type, any medication taken, name dosage & frequency: _____

6 ASTHMA Yes No If yes, identify type, severity, any medication taken, name, dosage & frequency: _____

7 DIABETES Yes No If yes, identify type, severity, any medication taken, name, dosage & frequency: _____

8 SEIZURE DISORDER Yes No If yes, identify type, severity, any medication taken, name, dosage & frequency: _____

9 HAS THE CANDIDATE EVER HAD ANY DISEASE, IMPAIRMENT OR ABNORMALITY OF:

Table with columns: System/Organ, YES, NO, YES, NO. Rows include Abdominal organs, Lungs, Bones/joints, Genito-urinary system, Heart blood vessels, Tonsils, Blood, Eyes/vision.

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

10 HAS THE CANDIDATE BEEN HOSPITALIZED?

Yes No If yes, give dates, diagnosis and outcome for each incident. _____

Blank lines for providing hospitalization details.



3b Health Certificate

FOR OFFICE USE

AFS ID#

Candidate Name (First/Middle/Last)

Home Country

11 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: _____

12 Has the candidate EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder? Yes No

13 Is there a history of, or present evidence of, an emotional, nervous or eating disorder? Yes No

If yes to either (12 or 13), 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 AFS 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.

14 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: _____

15 Does the candidate wear glasses or contact lenses? Yes No

16 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? _____

17 CANDIDATE HAS HAD THE FOLLOWING IMMUNIZATIONS, PLEASE SPECIFY EXACT DAY, MONTH AND YEAR:

	YES	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR
Measles	<input type="checkbox"/>	_____	_____	_____	_____	_____
Mumps	<input type="checkbox"/>	_____	_____	_____	_____	_____
Rubella	<input type="checkbox"/>	_____	_____	_____	_____	_____
Diphtheria	<input type="checkbox"/>	_____	_____	_____	_____	_____
Pertussis	<input type="checkbox"/>	_____	_____	_____	_____	_____
Tetanus	<input type="checkbox"/>	_____	_____	_____	_____	_____
Poliomyelitis	<input type="checkbox"/>	_____	_____	_____	_____	_____
BCG	<input type="checkbox"/>	_____	_____	_____	_____	_____
Hepatitis B	<input type="checkbox"/>	_____	_____	_____	_____	_____
Other	<input type="checkbox"/>	_____	_____	_____	_____	_____

TB Test Which type (circle one) Mantoux or Tine Date: _____ Result (+/-)

If positive, was chest x-ray done? Yes No Date _____ Result (+/-)

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 Form 3A and 3B, 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 AFS program.

Physician Name and Degree

Signature

Address

Date

Your signature below attests that you understand and accept the AFS Medical Policies as stated on the Participation Agreement, that the information on Form 3A and 3B is correct and complete and that inaccurate or incomplete information could be harmful to the candidate's health care and could result in early termination from the AFS program.

Candidate Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____



Name of participant

Date

AFS Program of participation

PERMISSION TO USE PHOTOGRAPHS AND VIDEO FOOTAGE

I understand that photographs and film and video footage (the "images") of current and former participants are occasionally used by AFS in promotional materials. By signing this Agreement, I grant to AFS the right to use, publish and/or reproduce for any lawful and legitimate purpose excerpts from interviews and letters, images and audio recordings and any other still or moving images of me taken during my involvement with AFS and to use my name in this connection. I understand that if I do not wish my images to be so used, I must mark the following box and initial the space beside it. By leaving this box blank, I understand that I will be deemed to have consented to such use.

Initial here if you DO NOT give permission for AFS to use such letters, images and audio recordings of yourself.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should any medical emergency arise, if time permits, AFS will communicate with the person(s) I have designated below as the emergency contact(s) through the National Office and request permission for surgery or other necessary treatment; however, if in the sole judgment of AFS, time and circumstances do not permit communication with them, I authorize AFS to consent to medical treatment, the administration of x-ray examination, anesthetics, blood transfusion, medical or surgical diagnosis or treatment and hospital care and to make medical evacuation arrangements and transport, if required, which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon.

I am aware that some local government may require certain vaccinations in order for myself to participate in community responsibilities. I understand that I am responsible for any costs related to these requirements.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize AFS, and/or its duly authorized medical consultant, to obtain all medical records relating to examinations or treatments for me while I am on the program and any other information concerning such examinations or treatments.

AGREED AND ACCEPTED:

Signature of participant

Participant's Birthdate:

day

month (spell word)

year

Name of emergency contact

Relationship

Work phone

Home phone

Address



Name of participant

Date

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PERMISSION TO PARTICIPATE IN THE KALEIDOSCOPE RESEARCH PROJECT

AFS is working with an independent research group to conduct a worldwide study named the Kaleidoscope Project. The aim of this project is to improve understanding of the impact of intercultural exchange programs. Participants will be invited by email from the research group to participate in a number of online questionnaires. At the end of the project, each participant will receive personalized feedback on their results. In the rare event of an early termination of the program, AFS will be contacted by the research group and asked to indicate one or more of seven broad reasons for the participant's early termination of the program, (e.g. "Participant has broken AFS rules"). Information provided by participants will be anonymously aggregated into the results and participant email addresses and other personally identifiable information will only be kept as long as necessary for purposes of conducting the study. We understand that if we do not want our son/ daughter to be invited to take part in this study, we may indicate this with our initials below and our child's contact information will not be shared with the independent group conducting the study and they will not be invited to participate. We understand that if we do not initial below, our child will be invited to participate in this survey. More information on the study may be found at: <http://www.kaleidoproject.org/>

Initial here if you DO NOT give permission for AFS to invite your child to participate in the worldwide research study.

AGREED AND ACCEPTED:

Signature of participant

Participant's Birthdate:

day

month (spell word)

year

Name of emergency contact

Relationship

Work phone

Home phone

Address