This form is to be completed by NSLI-Y semi-finalists who selected Academic Year as one of their duration preferences on the NSLI-Y application. Review and complete this form in entirety.

NSLI-Y MEDICAL REVIEW POLICIES

NSLI-Y requires a thorough and accurate profile of each candidate’s status so that program staff are aware of any past or present conditions that might affect the candidate’s ability to live, study, and travel abroad for an extended period. Please note that NSLI-Y staff are unable to provide medical advice; candidates and their parents/legal guardians are advised to consult with the Centers for Disease Control and Prevention guidance for travelers and their physician for guidance and other issues that affect health in the country where the candidate would like to study.

- The NSLI-Y program is a valuable experience and a time of growth for participants. It is important for candidates and their families to understand that by its nature, the academic year program can also be especially emotionally and physically demanding.
- Being immersed in a different culture, placed in an unfamiliar host family, school, and community often creates emotional stress during an adaptation period that varies in length and severity from person to person.
- Many services or accommodations that are widely available in the U.S., including those for individuals with disabilities or related to mental health, may not be available in the host country. Accommodations that are available may also vary from what is typical in U.S. classrooms. Some medications may not be available, are strictly controlled, or are illegal in the host country. NSLI-Y makes reasonable efforts to place and accommodate finalists with disabilities and medical needs.
- If a candidate is currently experiencing medical, emotional, psychological, or family difficulties or has only recently recovered from such issues, the adjustment demands of a study abroad program can severely exacerbate such difficulties or even cause a relapse.

USE OF MEDICAL INFORMATION

The information provided by candidates, parents, and health care professionals in the Medical Evaluation will not be considered during the selection process and will not be available to application evaluators. The Medical Evaluation Form will be reviewed by a medical professional after a candidate is selected as a finalist or an alternate to assess the candidate’s overall suitability for the NSLI-Y program.

Please be aware that some conditions cannot be accommodated in certain countries or areas of a country. In certain situations, after completion of the medical review process, NSLI-Y may determine that it cannot assure the safety and well-being of a candidate in a country where the preferred language is spoken. Therefore, a finalist may be offered placement in a country or location other than their first or second choice. In some cases, NSLI-Y may determine that it cannot safely place a finalist on any NSLI-Y program.

GUIDELINES FOR MEDICAL EVALUATION

The following guidelines will be used in determining a candidate’s medical qualification for the NSLI-Y program:

1. If the candidate has a history of, or presents evidence of a medical condition, the medical evaluation must show evidence that the candidate and candidate’s parents/legal guardians have an understanding of the condition, including any medication, treatment, or other accommodation necessary to manage the condition while on program. In some cases, to complete the medical evaluation process, NSLI-Y may require that a finalist and their parent/legal guardian(s) sign a waiver or agreement to acknowledge health risks and to confirm that the finalist can proactively manage the medical condition(s) in the host country.
2. Medication, treatment, or other accommodation necessary to manage the candidate’s condition must be legally available in the program, country, or region where the candidate is placed.

3. In cases where there is a significant health issue, a significant change in the candidate’s health or condition in the past year, and/or if a significant change is expected to occur during the candidate’s stay in the host country, American Councils and the program implementer cannot guarantee placement in a candidate’s preferred program site. American Councils and the program implementer will work with the candidate to try to arrange placement in a program site where the condition can be sufficiently accommodated, but a transfer placement is not guaranteed.

4. If a candidate’s health is dependent on regularly administered medication, or facilities are required for treatment of a chronic ailment or a physical condition, in addition to the criteria mentioned above, the candidate must show evidence of self-reliance in complying with prescribed treatment and any required self-administered medication.

Please note that while the above items constitute the basic guidelines, each candidate’s medical, emotional or psychological history will be evaluated on a case-by-case basis. Certain candidates who meet the above guidelines might still not be placed if NSLI-Y determines that an individual’s specific history, on-going condition, or prescribed medications, or some combination of the three would, in the opinion of NSLI-Y, pose significant risk for the candidate or the implementing organization if the candidate participated in one of the NSLI-Y programs.

MENTAL HEALTH AND STUDY ABROAD

In addition to physical health, the NSLI-Y Medical Evaluation Form requests information about the candidate’s mental health.

Why Does NSLI-Y Ask About Mental Health?

- Study abroad is a stressful experience and mental health conditions can intensify as a result.
- Many of the countries where NSLI-Y participants study do not have a strong (or any) network of mental health professionals (English speaking or otherwise).
- Some medications that U.S. students take to manage stress, anxiety, or other mental health issues are not available, or may be controlled or illegal in the host country. NSLI-Y staff members are not trained or equipped to monitor potential side-effects caused by such medications.
- The organizations and staff that implement NSLI-Y programs are not mental health professionals and cannot provide care or supervision for mental health conditions.

If any concerns are identified by our medical health staff during the medical evaluation form review, NSLI-Y administrative staff will also review the information and may conduct follow-up discussions with the finalist’s parents and/or medical providers. NSLI-Y staff will also discuss the issue with the implementing organization to which the finalist is assigned. Typically, if there have been no treatment changes in the past year and the doctor reports that the finalist’s condition is stable, NSLI-Y will only contact the finalist’s parents if additional information is needed for placement purposes.

If a concern is identified and/or there have been changes to mental health treatment in the past year, NSLI-Y staff will schedule a call with the finalist’s parents to discuss participation in the program. In some circumstances, NSLI-Y may request permission to speak with the finalist’s therapist or doctor and/or may request a written statement from the finalist’s therapist or doctor. This additional information may require that NSLI-Y staff review again the finalist’s condition with American Councils’ medical professionals and the implementing organization to which the finalist is assigned. If the medical qualification guidelines are not met, NSLI-Y may not be able to offer placement/participation to the finalist.
It is the responsibility of the candidate and the candidate’s parent(s)/legal guardian(s) to inform NSLI-Y of any health issue that could impact the candidate’s experience abroad. Adjustment issues can lead to depression or anxiety. For most participants, adjustment issues pass naturally over the course of time. For other participants, NSLI-Y staff will inform parents/legal guardians of the issues and discuss available treatment options. If a participant is 18 or older, the participant may decide whether to involve the parents/legal guardians in health-related discussions, which is encouraged by the NSLI-Y program. In some cases, the implementing organization may be able to arrange for mental health services. Participants with severe anxiety, depression, or other mental health issues may need to return home for treatment. Decisions about repatriation are made in consultation with the U.S. Department of State, American Councils, and the implementing organization. If a participant experiences mental health issues as a result of an incident that occurs while on program, NSLI-Y staff will work with in-country or U.S. medical professionals to diagnose and treat the participant. If treatment can be effectively provided in-country in a reasonable period of time, the program will assist the participant in receiving appropriate treatment.

Please be aware that if the candidate and parent(s)/legal guardian(s) do not agree to the mental health portion of the HIPAA release (page 9), staff will be limited in 1) facilitating the medical review for placement and 2) providing support in facilitating an assessment or treatment if needed on program.

**DISCLAIMER**

The medical review process begins only after an applicant is selected as a finalist or alternate. The review process can take several weeks, depending on the follow-up required, which may include contacting a finalist’s health care provider. To avoid unnecessary delays, we encourage parents/legal guardians of finalists who require additional medical review or who must complete the Mental Health Certification to contact the relevant professionals to explain the importance of returning calls to the NSLI-Y staff handling the review process.

NSLI-Y is committed to providing reasonable accommodations for individuals with disabilities to participate in the program. American Council’s Disability Accommodations Policy is available upon request by emailing nsly@americancouncils.org. In order to accommodate the needs of the candidate, the Health Certificate included in the NSLI-Y Application must be thoroughly completed. Please note that a positive recommendation by a candidate’s mental health professional or medical doctor does not guarantee that the candidate will be approved for participation in NSLI-Y.

Candidates traveling to countries with complicated and lengthy visa application processes may be asked to begin the visa application process before the medical review is completed. This does not mean that the candidate has been approved for participation in NSLI-Y.

Even if a candidate has been selected for a scholarship, acceptance may be annulled at any time before the beginning of the program should the medical review fail to resolve concerns regarding the student’s fitness to participate in the NSLI-Y Program. Withholding or falsifying information about a physical or mental health condition will likely result in cancellation of the NSLI-Y scholarship and/or dismissal from the program.

**NON-DISCRIMINATION STATEMENT**

American Councils and the NSLI-Y program implementers do not consider or discriminate on the basis of race, creed, color, ethnicity, religion, national origin, gender, sexual orientation, disability, or medical condition in reviewing and selecting scholarship finalists.
INSTRUCTIONS FOR COMPLETING THE MEDICAL EVALUATION

This form MUST be filled out completely and accurately. The candidate and parent(s)/legal guardian(s) MUST sign page 8 of the form.

- Part A is the Candidate Health Self-Assessment which the applicant and parent(s)/legal guardian(s) must complete.

- Part B is a Health Certificate that the candidate’s primary health care provider must complete based on a medical exam performed in the past three months. The health care provider must review the candidate’s health self-assessment before completing the health certificate. The physician or nurse must not be related to the candidate.

- Part C is a Mental Health Certification to be completed only if questions 6.9 or 6.10 of the Health Certificate (Part B) is answered in the affirmative. The mental health professional must not be related to the candidate.

- Part D must be completed by the candidate’s dentist.

NSLI-Y reserves the right to ask for additional information to determine if a finalist can be placed in a particular program or country. Please review the NSLI-Y Medical Review Policies at the beginning of this form. Please retain a completed copy of the medical evaluation form for your records. Submit all completed sections (p 6 and higher) to NSLI-Y at American Councils through the NSLI-Y Semi-Finalist portal at https://ais.americancouncils.org/nsliySF (using application log-in credentials) by February 20, 2020 (11:59 PM Eastern Time). Ensure full completion of the form. Incomplete forms will be returned and will cause a delay in the medical review process.

Candidates and their parent(s)/legal guardian(s) are responsible for notifying American Councils of any changes to the candidate’s health or medical conditions prior to the start of their program. Failure to do so will likely result in cancellation of the NSLI-Y scholarship and/or dismissal from the program.

TIMELINE FOR THE MEDICAL EVALUATION

- February 20 (11:59 PM EST): Deadline for semi-finalists to submit medical evaluation form using the online portal, https://ais.americancouncils.org/nsliySF

- February – March: During this period, semi-finalists may be contacted by program staff if portions of their medical evaluation form are incomplete. Medical evaluation forms are only reviewed for completeness at this time.

- March – April: Medical professionals will begin the medical review after finalists are selected.

- May - June: NSLI-Y staff may contact finalists and/or their parent(s)/legal guardian(s) if:
  
  o Medical professionals require additional information to complete the medical review. This may require that the finalist’s family arrange for NSLI-Y staff to speak with the finalist’s physician or other health care provider
  o Additional information is needed for placement purposes
  o NSLI-Y determines that it cannot assure the safety and well-being of a finalist in a country where the preferred language is spoken. During this period:
    ▪ A finalist may be offered placement in a country or location other than the first or second choice, or
    ▪ NSLI-Y may determine that it cannot safely place a finalist on any NSLI-Y program
CHECKLIST

☐ Review pages 1-4 with your parent(s)/legal guardian(s).
☐ Complete pages 6-8 with your parent(s)/legal guardian(s).
☐ Review and sign page 8. At least one of your parents/legal guardians must also sign.
☐ Review and sign page 9 if you authorize use or disclosure of protected health information under HIPAA if selected as a finalist/alternate. Check applicable areas under “Sensitive Medical Records”; this is especially important if you are required to submit Part C. Please be aware that if you do not agree to the HIPAA release, staff will be limited in 1) facilitating the medical review for placement and 2) offering support in facilitating an assessment or treatment if needed on program. (Note that influenza, for example, would be classified as a communicable disease. Therapy for anxiety or depression would be classified as mental health.)
☐ If questions 6.9 or 6.10 on page 13 are answered YES, ask your psychologist or psychiatrist to complete Part C, pages 14-15. The psychologist/psychiatrist must sign page 15.
☐ Scan pages 6-13 + 16 in numerical order as one PDF document. Also include 14-15 if applicable.
☐ Ensure full and accurate completion of the form. If any boxes are unchecked or not filled out, NSLI-Y staff will request the missing information, thus resulting in delays in completing the medical review.
☐ Upload the PDF document by **February 20, 2020** at: [https://ais.americancouncils.org/nsliySF](https://ais.americancouncils.org/nsliySF)
PART A – CANDIDATE HEALTH SELF-ASSESSMENT (To be completed by the applicant and parent(s)/legal guardian(s))

NSLI-Y strives to provide a safe and rewarding experience abroad to all participants. Studying abroad can be a stressful experience; mental health conditions that may be managed at home may become more difficult or not possible to manage overseas. It is also important to keep in mind that many services or accommodations that are widely available in the U.S., including those for people with disabilities or related to mental health, may be limited or unavailable in the host country. Some medications may not be available, may be strictly controlled, or illegal in the host country. Disclosing information about the candidate’s current health condition(s) will help the NSLI-Y program implementer determine a suitable placement. Failure to disclose medical history may result in the termination of the candidate’s NSLI-Y scholarship. Questions about this form or accommodations for disabilities should be addressed to nsly@americancouncils.org. Please ensure full completion of the form.

1. Do you have a chronic/recurrent illness, infection or condition that you take medication for or have been treated for including, but not limited to, cancer, chronic fatigue syndrome, colitis, diabetes, epilepsy, hypertension, HIV-AIDS, lupus, rheumatoid arthritis, etc.?  ☐ Yes ☐ No

2. Do you have a history of asthma or other respiratory ailment?  ☐ Yes ☐ No
   If yes, do you plan to bring an inhaler on program?  ☐ Yes ☐ No

3. Do you have Celiac disease or another gastrointestinal disorder?  ☐ Yes ☐ No

4. Do you have any cardiologic issues?  ☐ Yes ☐ No
   If you answered yes to any of the questions above, please describe your condition(s), how you manage and function with the condition(s) and any accommodations you may need to manage the condition(s): ___________________________ ___________________________

5. Do you have any allergies?  ☐ Yes ☐ No
   Is there a risk of anaphylactic shock?  ☐ Yes ☐ No
   Have you ever been advised to carry an epi pen?  ☐ Yes ☐ No
   If you answered yes to any of these questions, please describe the allergy, symptoms, how you manage this allergy, and any accommodations you may need to manage the allergy: ___________________________ ___________________________ ___________________________

6. Are you currently receiving on-going medical treatment for any condition, including antigen/immunotherapy injections or prescription medication?  ☐ Yes ☐ No
   If yes, please provide details, whether you will require ongoing treatment while abroad, and, if so, how you plan to continue receiving this treatment while on program: ___________________________ ___________________________ ___________________________

7. Are you blind or do you have low vision?  ☐ Yes ☐ No
8. Do you have hearing loss?  ☐ Yes ☐ No
   If yes, do you use a hearing aid, cochlear implant or other assistive device?  ☐ Yes ☐ No
9. Do you have a physical or mobility related disability?  ☐ Yes ☐ No
If you answered yes to questions 7, 8, or 9, please provide details and any accommodations that may be needed, as well as assistive devices used: ________________________________

10. Have you been hospitalized in the last 12 months?  
☐ Yes  ☐ No  
If yes, please provide details, including dates, and any required ongoing care relating to that event or condition.

11. Do you have any dietary restrictions or food allergies for medical reasons?  
☐ Yes  ☐ No
12. Do you have any dietary or fasting requirements for personal or religious reasons?  
☐ Yes  ☐ No
If yes, please provide details, including how you currently manage this aspect of your health and any accommodations or support that you may need while you are abroad.

13. Are you vegan or vegetarian?  
☐ Yes  ☐ No
If yes, do you eat any of the following: dairy products, eggs, fish, poultry, other, or none of the above?

14. Have you ever been diagnosed with or experienced depression; severe anxiety; drug/alcohol dependence; emotional, nervous, or eating disorders; or any mental health conditions?  
☐ Yes  ☐ No
If yes, please provide the following:  
Dates and duration of episodes and treatment received: ________________________________
What medications (if any) are you taking? Please include dosage ________________________________
How do you currently manage the condition? Please share your coping mechanism and strategies.

Please discuss any accommodations or support that you may need while abroad.

15. List all over-the-counter or prescription medications that you take regularly or that you anticipate needing to take while abroad. If you list any medications, please explain the reason you are taking or plan to take the medication.

16. Have you ever been diagnosed with a learning disability?  
☐ Yes  ☐ No
If yes, please provide additional details about the disability, including any accommodations that you have received, and any accommodations or support you may need while abroad.

17. Do you wear orthodontic braces?  
☐ Yes  ☐ No
If yes, will you require orthodontic care while abroad?  
☐ Yes  ☐ No

18. Do you currently have any dental problems, i.e. unfilled cavities, impacted teeth, or abscessed teeth?  
☐ Yes  ☐ No

19. Do you smoke?  
☐ Yes  ☐ No
If yes, will you smoke while participating in NSLI-Y?

☐ Yes  ☐ No
CANDIDATE/PARENT ACKNOWLEDGEMENT, CERTIFICATION & CONSENT TO RELEASE OF MEDICAL INFORMATION

1. The signatures below attest that the information provided on the Candidate Health Self-Assessment Form is correct and complete, and acknowledge that failure to provide accurate or complete information could be harmful to the candidate’s health and may result in dismissal from the NSLI-Y program. The signatures below confirm that the candidate/parent/legal guardian will inform NSLI-Y (nsly@americancouncils.org) promptly if there are changes to the candidate’s health after submission of this form.

2. The signatures below acknowledge that NSLI-Y participants, unless otherwise required or specified by a NSLI-Y implementing organization or host country laws, are required to solely assume responsibility for maintaining their own prescription drug regimen for the duration of their program. This includes carrying, properly storing, and administering medications.

3. The signatures below acknowledge that certain NSLI-Y host countries may require proof of specific immunizations for entry. By signing, the candidate and parent/legal guardian also confirm understanding that it is the candidate’s and parent’s/legal guardian’s responsibility to consult with medical professionals to learn about and monitor specific vaccine and health recommendations for the assigned host country. NSLI-Y host countries may present health risks including injury, illness, or death to individuals without the immunizations recommended by the Center for Disease Control and Prevention. The candidate and parent/legal guardian understand that NSLI-Y is unable to provide guidance regarding immunizations and that a lack of certain immunizations could affect program placement. (For more health information for travelers, please visit: http://wwwnc.cdc.gov/travel/destinations/list.)

4. The signatures below confirm understanding and acknowledgement of NSLI-Y Medical Review Policies, Use of Medical Information, Guidelines for Medical Evaluation, Mental Health and Study Abroad, Disclaimer, Non-Discrimination Statement, and Timeline on pages 1-4 on this form.

5. The signatures below confirm that the candidate and parent(s)/legal guardian(s) authorize the release of medical information as described below on page 9, and that they understand that incomplete or inaccurate information could be harmful to the candidate’s health care and could result in early termination from the NSLI-Y program.

At least one person who signs below must be listed in the candidate’s online application as a parent or guardian.

---

Candidate Signature: ___________________________ Date (mm/dd/yyyy): _____________

Parent/Legal Guardian Signature: ___________________________ Date (mm/dd/yyyy): _____________

Parent/Legal Guardian Signature: ___________________________ Date (mm/dd/yyyy): _____________
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

1. The signatures below authorize American Councils for International Education and NSLI-Y implementing partners (collectively “NSLI-Y”) to discuss and/or release protected health information (“PHI”), as defined in the Health Insurance Portability and Accountability Act (“HIPAA”) obtained or made in connection with an evaluation of a student’s medical condition and/or medical treatment, payment or NSLI-Y’s operations while on program to the student’s parents or guardians, NSLI-Y implementing partners, host families, and to third parties involved in the candidate’s placement or health care while on program, including the U.S. Department of State, health insurance companies, and/or health insurance payment processors.

2. The candidate and parent(s) authorize the following protected health information (PHI), not including Sensitive Medical Records as described below, to be released:
   - Records, including immunization records
   - Reports
   - Medical histories
   - Test results, including x-rays
   - Diagnoses
   - Prognoses

SENSITIVE MEDICAL RECORDS RELEASE

3. NSLI-Y IS NOT authorized to release mental health records/information, alcohol and/or drug abuse/treatment/referral records/information, communicable disease records/information or HIV/AIDS-related records/information (“Sensitive Medical Records”) except when reportable by law to public health agencies or unless specifically authorized to do so below. In order to release sensitive information regarding mental health, alcohol and/or drug abuse/treatment/referral, communicable disease or HIV/AIDS-related treatment, the appropriate box or boxes must be checked.

4. Please refer to NSLI-Y’s Medical Review Policies (pages 1-4) for information relating to the potential use of information about a candidate’s Sensitive Medical Records.

5. By signing and checking the categories below, the candidate and parent(s) are authorizing NSLI-Y to discuss and/or release to the candidate’s parents or guardians, NSLI-Y implementing partners, host families, and to third parties including the U.S. Department of State or other third parties involved in the candidate’s health care information about the candidate’s Sensitive Medical Records, as designated below. (Please check all that apply.)
   - ___ Alcohol/Drug Abuse, Treatment, Referral
   - ___ HIV/AIDS-Related Treatment
   - ___ Communicable Diseases [e.g., hepatitis]
   - ___ Mental Health [other than Psychotherapy Notes]
   - ___ Psychotherapy Notes (by checking this box, I am waiving any psychotherapist-patient privilege)

6. The undersigned may revoke this authorization as to his/her medical records/information at any time except to the extent that action has been taken in reliance thereon. It is also understood that this authorization shall remain valid during the Medical Review process and for the duration of the program plus sixty (60) days unless the authorization is revoked prior to the expiration of sixty (60) days. If the undersigned chooses not to provide this authorization or to revoke his/her authorization once provided, the student may send a written instruction by email or mail to Emily Matts Henry (nsliy@americancouncils.org). Revocation will not apply to information that has already been disclosed in response to this authorization.

7. Information disclosed under this authorization might be redisclosed by the recipient, with certain exceptions for Sensitive Medical Records, and this redisclosure may no longer be protected by federal or state law, including HIPAA.

At least one person who signs below must be listed in the student’s online application as a parent or guardian.

<table>
<thead>
<tr>
<th>Candidate Signature</th>
<th>Date (mm/dd/yyyy)</th>
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<tbody>
<tr>
<td>Parent/Legal Guardian Signature</td>
<td>Date (mm/dd/yyyy)</td>
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<tr>
<td>Parent/Legal Guardian Signature</td>
<td>Date (mm/dd/yyyy)</td>
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</tbody>
</table>
2020-21 Academic Year Programs
Medical Evaluation Form

Application Reference Number: _____________________   Candidate’s Name: _____________________
Last Name: _____________________   First Name: _____________________   M.I.: _____________________

PART B – HEALTH CERTIFICATE (To be completed by the candidate’s health care professional.)

To the candidate’s physician, physician’s assistant, or nurse practitioner -

This student is an applicant for a study abroad program where the standard of medical care may be lower than in the United States, where access to treatment or medication may be restricted, where nutrition or environmental factors may exacerbate existing health conditions, and where the ability to accommodate certain medical conditions may be limited. Please complete this form based on information provided to you by the applicant on the Candidate Self-Assessment Form, a review of the Form and all relevant medical records, a recent physical examination of the patient (within 3 months of completion of this form), and discussion with the student. Please give especially detailed information on any medical or psychological conditions that might be of concern during the student's time overseas. Please be sure to check all boxes and complete all requested information. After completing this form, please return it to the student.

1. Date of examination: _____________________
   MM/DD/YYYY (within last 3 months)

2. MEDICAL HISTORY. Has the candidate ever received treatment, attention or advice from a physician or other practitioner for, or been told by any physician or practitioner that the candidate had any of the following? Please check Yes or No for all items:

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Disease/Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>2.1</td>
<td>Allergies to Medications/Vaccines</td>
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<tr>
<td>2.2</td>
<td>Other Allergies (including food related)</td>
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<td>2.3</td>
<td>Asthma</td>
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<td>2.4</td>
<td>Tuberculosis</td>
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<td>2.5</td>
<td>Chronic/Rec当前 呼吸道疾病</td>
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<td>2.6</td>
<td>Rheumatic Fever</td>
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<td>2.7</td>
<td>Heart Disease or Abnormality</td>
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<td>2.8</td>
<td>Gastrointestinal Disorder</td>
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<td>2.9</td>
<td>Enuresis</td>
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<td>2.10</td>
<td>Persistent or Recurrent Headache</td>
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<td>2.11</td>
<td>Migraines</td>
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<td>2.12</td>
<td>Seizure Disorder (Epilepsy)</td>
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<td>2.13</td>
<td>Other Neurological Abnormality/Disease</td>
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<td>2.14</td>
<td>Thyroid Abnormality/Disease</td>
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<td>2.15</td>
<td>Kidney or Urinary Tract Disease (chronic or recurring)</td>
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<td>2.16</td>
<td>Vascular problems/Hypertension</td>
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<td>Diabetes Mellitus</td>
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<td>Other Endocrine Abnormality/Disease</td>
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<td>2.19</td>
<td>Chronic or Recurrent Arthritis</td>
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<td>2.20</td>
<td>Muscle Disease or Skeletal Abnormality</td>
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<td>2.21</td>
<td>Chronic or recurrent Skin Condition</td>
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<td>Cancer or Leukemia</td>
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<td>Vision loss/ Eye Disease</td>
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<td>Hearing loss</td>
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<td>2.25</td>
<td>Parasites (internal)</td>
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<td>2.26</td>
<td>Anorexia/Bulimia/Weight Problems</td>
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<td>2.27</td>
<td>Mental health condition</td>
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<td>2.28</td>
<td>Learning Disability</td>
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<td>2.29</td>
<td>Sexually Transmitted Diseases</td>
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<td>2.30</td>
<td>HIV/AIDS</td>
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<td>2.31</td>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.32</td>
<td>Severe Acne</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.33</td>
<td>Appendicitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.34</td>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.35</td>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.36</td>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.37</td>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.38</td>
<td>Gender dysphoria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.39</td>
<td>Other childhood disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YOU ANSWER “YES” TO ANY OF THE ABOVE ITEMS, please provide detailed information and dates even if the condition is no longer active. Please identify the condition by Item Number (attach extra pages if necessary):

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Date of most recent symptoms or attack</th>
<th>Incidence duration</th>
<th>Specific diagnosis; severity; current treatment (including medications); dosage; ongoing treatment</th>
<th>Current Status (active, in remission, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

10
PART B – HEALTH CERTIFICATE CONTINUED

3. IMMUNIZATIONS. Can the student receive immunizations? □ Yes □ No

If “No,” explain: ________________________________________________________________
_______________________________________________________________

An accurate and complete immunization record is required. Please specify all dates for all doses (since birth):

<table>
<thead>
<tr>
<th>3.1 Diphtheria, Pertussis, Tetanus</th>
<th>DOSE 1 Date: <strong>/</strong>/__</th>
<th>DOSE 2 Date: <strong>/</strong>/__</th>
<th>DOSE 3 Date: <strong>/</strong>/__</th>
<th>DOSE 4 Date: <strong>/</strong>/__</th>
<th>DOSE 5 Date: <strong>/</strong>/__</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2 Tdap</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Poliomyelitis (trivalent oral or IPV)</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td>DOSE 3 Date: <strong>/</strong>/__</td>
<td>DOSE 4 Date: <strong>/</strong>/__</td>
<td>DOSE 5 Date: <strong>/</strong>/__</td>
</tr>
<tr>
<td>3.4 Measles/ Mumps/ Rubella</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td>DOSE 3 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Hepatitis A</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td>DOSE 3 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6 Hepatitis B</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td>DOSE 3 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.7 Varicella/Chicken Pox</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.8 Meningitis</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9 Pneumococcal</td>
<td>DOSE 1 Date: <strong>/</strong>/__</td>
<td>DOSE 2 Date: <strong>/</strong>/__</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.10 Other (Typhoid, HPV, Yellow Fever, Cholera)</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
</tr>
<tr>
<td>3.11 Other (Typhoid, HPV, Yellow Fever, Cholera)</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
<td>VACCINE Date: <strong>/</strong>/__</td>
</tr>
</tbody>
</table>

4. PHYSICAL EXAMINATION. Complete the following based on your physical examination of the student. Forms with incomplete items will be returned.

4.1 Height ______ Weight ______ BMI ______ BMI Percentile ______ Blood Pressure _______ Pulse_______

4.2 Do you note any abnormalities or health concerns concerning height, weight (including substantial loss or gain in the past six months)? □ Yes □ No

4.3 Are blood pressure, pulse, or respiration abnormal? □ Yes □ No

If “Yes” to above questions, explain: ___________________________________________________________
2020-21 Academic Year Programs
Medical Evaluation Form

Application Reference Number: _____________________  Candidate’s Name: _____________________

Last     First     M.I.

PART B – HEALTH CERTIFICATE CONTINUED

4.4 Does the candidate have any current disease, impairment, or abnormality of the following? (Check Yes or No for each item). If “YES”, please provide details:

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Specific diagnosis; severity of abnormality; recommended treatment (including medications and surgery; need for follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4.a</td>
<td>Eyes</td>
</tr>
<tr>
<td>4.4.b</td>
<td>Ears</td>
</tr>
<tr>
<td>4.4.c</td>
<td>Nose or Throat</td>
</tr>
<tr>
<td>4.4.d</td>
<td>Lungs or Respiratory System</td>
</tr>
<tr>
<td>4.4.e</td>
<td>Heart or Cardiovascular System</td>
</tr>
<tr>
<td>4.4.f</td>
<td>Abdomen or Abdominal Organs</td>
</tr>
<tr>
<td>4.4.g</td>
<td>Urinary System</td>
</tr>
<tr>
<td>4.4.h</td>
<td>Thyroid gland or Endocrine System</td>
</tr>
<tr>
<td>4.4.i</td>
<td>Bones or Joints</td>
</tr>
<tr>
<td>4.4.j</td>
<td>Muscles or Skeletal System</td>
</tr>
<tr>
<td>4.4.k</td>
<td>Brain or Nervous System</td>
</tr>
<tr>
<td>4.4.l</td>
<td>Abdomen or Abdominal Organs</td>
</tr>
<tr>
<td>4.4.m</td>
<td>For Women: Breast, Ovaries or Genitalia</td>
</tr>
<tr>
<td>4.4.n</td>
<td>For Men: Testes or Genitalia</td>
</tr>
<tr>
<td>4.4.o</td>
<td>High Blood Pressure</td>
</tr>
</tbody>
</table>

5. TUBERCULOSIS  Note: NSLI-Y programs take place in countries where the prevalence of TB is higher than in the U.S. All Academic Year candidates must include TB test results from the last 3 months. The date and result from ONE (1) of the following TB tests is required.

<table>
<thead>
<tr>
<th>TB skin test</th>
<th>TB IGRA Blood Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Placed: <strong>/</strong>/__</td>
<td>Date of test: <strong>/</strong>/__</td>
</tr>
<tr>
<td>Date Read: <strong>/</strong>/__</td>
<td></td>
</tr>
<tr>
<td>Result in mm: __</td>
<td>Negative</td>
</tr>
<tr>
<td></td>
<td>Indeterminate</td>
</tr>
<tr>
<td></td>
<td>Borderline</td>
</tr>
</tbody>
</table>

Has the candidate ever had any of the following? (Check “Yes” or “No” for each item):

- Persistent cough
- Weight loss
- Abnormal chest x-ray
- Bloody sputum or any other sign or symptom of tuberculosis

6. ADDITIONAL QUESTIONS FOR THE HEALTH PROFESSIONAL  Check Yes or No for each question. If “Yes”, please provide detail and dates, if relevant.

6.1. Has the candidate ever been hospitalized?  Yes ☐ No ☐

6.2. Does the candidate have a medical condition that would prohibit the candidate from living in a home with smokers? (Please be advised that smoking is more common in many NSLI-Y host countries than in the U.S., therefore NSLI-Y is unable to guarantee a smoke-free homestay for all candidates.)  Yes ☐ No ☐

6.3. Does the candidate have any allergies and/or has the candidate tested positively for any allergies? If “Yes,” specify the reaction and severity.  Yes ☐ No ☐

6.4. Is the candidate currently taking medication or injections (other than any mentioned previously)?  Yes ☐ No ☐

6.5. Are there any health limitations or restrictions on the candidate’s activities and/or sports participation or any medical information that should be considered for a home/school placement?  Yes ☐ No ☐

6.6. Has the candidate ever tested positively for Celiac Disease?  Yes ☐ No ☐

6.7. Does the candidate wear glasses or contact lenses?  Yes ☐ No ☐
Application Reference Number: _____________________  Candidate’s Name: _____________________

PART B – HEALTH CERTIFICATE CONTINUED

6.8. Have there been any changes in the candidate’s medical treatment or medications in the past year? If yes, please provide an explanation.

□ Yes □ No
________________________________________________________________________________________________________________
_________________________________________________________________________________

6.9. Has the candidate ever consulted, or is currently consulting a mental health professional (including, but not limited to a psychologist, family counselor, psychiatrist, social worker, drug or alcohol dependence counselor, trauma counselor, family therapist, etc.) for depression; anxiety; drug/alcohol dependence; emotional, nervous, learning, or eating disorder; or any mental health condition?

□ Yes* □ No
________________________________________________________________________________________________________________

6.10. Is there a history of, or present evidence of, depression; anxiety; drug/alcohol dependence; emotional, nervous, learning, or eating disorder; or any mental health conditions?

□ Yes* □ No
________________________________________________________________________________________________________________

REQUIREMENT FOR MENTAL HEALTH CERTIFICATION

*IMPORTANT! If either question 6.9 or 6.10 is answered “YES,” please note that the Mental Health Certification, Part C of this form, must be completed by the candidate’s mental health professional (including, but not limited to a psychologist, family counselor, psychiatrist, social worker, drug or alcohol dependence counselor, trauma counselor, family therapist, etc.). The mental health professional must not be related to the candidate.

7. HEALTH CERTIFICATION. Based on the information provided to me by the patient on the Candidate Self-Assessment Form, a review of the Form and all relevant medical records, a physical examination of the patient, and discussion with the patient, to the best of my knowledge:

❑ The patient has no current medical condition or issue that restricts or prevents participation in a study abroad program.

❑ The patient has a current medical condition or issue, but it is not expected to restrict participation in a study abroad program if the patient manages it as described below. Medical problems and concerns have been addressed, and the patient was educated on the use of any medication, treatment, or accommodation needed to control current medical condition(s) during the study-abroad program.

❑ The patient has a current medical condition or issue that may restrict or prevent participation in a study abroad program.

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 NSLI-Y program.

__________________________________________________________
Signature

__________________________________________________________
Date (mm/dd/yyyy)

Provider Name and Qualification (MD, DO, PA, NP)

Address

Phone
TO BE COMPLETED BY CANDIDATE’S MENTAL HEALTH PROFESSIONAL

The information below, along with the candidate’s completed application, will be used in determining the candidate’s suitability for an overseas language immersion program and/or the most appropriate program and country placement. Please note that a recommendation from a mental health professional does not guarantee participation in the NSLI-Y program or placement in a particular host country or region. This information is confidential and will be seen only by program staff after scholarship selections are made.

Placement in a foreign host family, school, and community requires significant adjustment that often creates emotional stress. If the candidate is currently experiencing emotional, physical, personal, or family difficulties, these difficulties can be severely exacerbated by the adjustment demands of studying abroad. Please carefully evaluate 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.

When making your recommendation, please consider:

- Study abroad is a demanding and stressful experience.
- Mental health treatment will not be available to a student while on program.
- Depression and anxiety may not be commonly diagnosed or treated in the host country.
- NSLI-Y staff cannot be responsible for monitoring side effects caused by anti-depressant and anti-anxiety medications.

1. Would you recommend this candidate for a study abroad experience?

   ☐ Yes  ☐ With reservations  ☐ No

1.1. If you answered “with reservations” or “no,” please explain your reasoning below. Additional comments can be provided in an attachment, if necessary: ____________________________________________________________
                                                                                                      ____________________________________________________________
                                                                                                      ____________________________________________________________
                                                                                                      ____________________________________________________________
                                                                                                      ____________________________________________________________

2. Has this candidate ever received treatment from a mental health professional (including, but not limited to a psychologist, psychiatrist, social worker, drug or alcohol dependence counselor, trauma counselor, family therapist, etc.)?  ☐ Yes  ☐ No

2.1. If yes, please provide information about past treatment (including symptoms, diagnosis; dates and frequency of treatment; and medication). ____________________________________________________________
                                                                                                      ____________________________________________________________
                                                                                                      ____________________________________________________________
                                                                                                      ____________________________________________________________
                                                                                                      ____________________________________________________________

PART C – ADDITIONAL INFORMATION - MENTAL HEALTH (This form is required only if either question 6.9 or 6.10 in PART B of the Health Certificate was answered “Yes.”) (To be completed by the candidate’s health care professional.)
### 2020-21 Academic Year Programs
**Medical Evaluation Form**

Application Reference Number: _____________________   Candidate’s Name: _____________________

#### PART C – MENTAL HEALTH – CONTINUED

2.2. Have there been any changes in the student’s mental health treatment in the last year?  
   □ Yes □ No
   If yes, please specify.
   ________________________________________________________________________________________

2.3. Is this candidate likely to have an adverse reaction to the cessation of psychotherapy during the NSLI-Y experience?  
   □ Yes □ No
   If yes, please explain.
   ________________________________________________________________________________________

3. **IF THE CANDIDATE IS CURRENTLY TAKING MEDICATION OR HAS TAKEN MEDICATION IN THE LAST YEAR RELATED TO A MENTAL HEALTH CONDITION:**

3.1. Name of medication(s) and current dosage(s):
   ________________________________________________________________________________________

3.2. For what condition(s) was medication prescribed?
   ________________________________________________________________________________________

3.3. When was the medication first prescribed?
   ________________________________________________________________________________________

3.4. What was the highest dosage?
   ________________________________________________________________________________________

3.5. Have there been any changes in medication in the last year?  
   □ Yes □ No
   If yes, please specify date, details of change, and reason for adjustment.
   ________________________________________________________________________________________

Will the candidate need to take medication during the study abroad experience?  
□ Yes □ No
If yes, please specify type(s) and dosage(s):
   ________________________________________________________________________________________

**PROVIDER SIGNATURE**

________________________________________________________________________________________
Signature

________________________________________________________________________________________
Date (mm/dd/yyyy)

Provider Name and Qualification

________________________________________________________________________________________
Address

________________________________________________________________________________________
Phone
TO BE COMPLETED BY CANDIDATE’S DENTIST

To the dentist –

The information below, along with the candidate’s completed application, will be used in determining the candidate’s ability to participate in an overseas language immersion program. It is unlikely that participants will have access to preventative dental services for the duration of the program.

Date of examination: ________________________

1. Are the student’s teeth and gums in healthy condition? □ Yes □ No
   If no, please explain in detail: ________________________________________________________________

   If dental work is needed, provide the date it was/will be completed: ________________________________

2. The student wears: □ fixed braces □ removable orthodontia devices □ neither
   2.1. If the student wears fixed braces, will they be removed before he/she departs the US? □ Yes □ No
   2.2. Is follow up required? □ Yes □ No
   2.3. If yes, explain required follow-up and timing: ________________________________________________

PROVIDER SIGNATURE

_________________________________________________________ Date (mm/dd/yyyy)

Signature

Provider Name and Qualification ____________________________________________

Address _________________________________________________________________

Phone ________________________________