Global Youth Ambassador Project
Classroom Immersion

CANDIDATE APPLICATION
GYAP CHINA STUDENT IMMERSION PROGRAM

Attach photo here

First Name _____ Last Name _____

Address _____ Home Country _____

Date of Birth _____ Birth Place _____

Visiting Country _____

1. Basic Personal Information

1 CANDIDATE'S NAME
First Name Middle Name Last Name Title (if applicable)
2 ADDRESS FOR MAILING PURPOSES
Street:
City: Postal Code:
Telephone: Fax:
E-mail address: Date of Birth (day/month/year)
3 FOR VISA PURPOSES
City of Birth: Country of Birth:
Country of Citizenship: Country of Legal Residence:
Passport Number: Passport Issue Date:
Place/Office of Passport Issue:
Passport Expiration Date:
4 INFORMATION ABOUT THE PEOPLE WITH WHOM I LIVE
I live with: ( ) Spouse ( ) Alone ( ) Other:
Detail of person with whom you live:
First Name Last Name:
Date of Birth Country of Birth Occupation
Business and/or Mobile Phone Email
5 EMERGENCT CONTACT
If the person with whom you live cannot be reached, please indicate someone else in your community whom we can contact
First name Last Name Relationship Telephone Number (home, work, mobile)

2. School Information

School Name	
School Address	
Schoo Contact Person	
Contact Information	

3. Personal Statement

You should connect together different education/ life experiences you have had, to give a big picture of what you have done and their relevance to what you want to do in the future.

The personal statement is your only piece of creative writing in your application packet. You should cover the following topics:

Your education background.
Your expectations of this program.
What are your strong points?
What are your weak points?
Why you apply for this program.

4. Placement Information

1 CANDIDATE'S NAME

_____

Candidate's name City State/Province/Region

2 MEDICAL REQUIREMENTS AND HEALTH RESTRICTION

Do you have physical restrictions, impairments or allergies that will limit placement options or participation in everyday family and / or school activities ☐ Yes ☐ No If yes, please explain:

_____

Can you live with: **Cats:** ☐Indoors? ☐Outdoors? **Dogs**: ☐Indoors? ☐Outdoors? **Other pets:** ☐Indoors? ☐Outdoors? If not, please explain:_____

3 DIETARY REQUIREMENTS

Do you have dietary restrictions, including for medical, religious or self-imposed reasons?
☐Yes ☐No If yes, please explain:_____

If you are a vegetarian, are you willing to eat: ☐Fish ☐Poultry ☐Dairy projects

4 RELIGION

What is your religious affiliation, if any? (Optional):_____
How often do you participate in structured religious services?
☐Weekly ☐Monthly ☐Occasionally ☐Never

Bearing in mind that it is likely that your host family will have different religious affiliation, how strongly do you feel about having access to structured religious services of your own faith?
☐Required ☐Not necessary

5 SMOKING

Do you smoke cigarettes? ☐Yes ☐No

In some cultures it is more difficult to find placement for cigarette smokers. Given this, smokers should please choose one of the following: ☐I will not smoke in my host family house ☐I will smoke in my host family house

6 INTERESTS AND ACTIVITIES

Identify your major interests and activities and indicate how often you pursue them:

_____

7 LANGUAGES

Native language: _____
Language proficiency (for languages other than your native language):
Language _____ Years studies _____ Speaking ability: ☐Poor ☐Fair ☐Good ☐Excellent
Language _____ Years studies _____ Speaking ability: ☐Poor ☐Fair ☐Good ☐Excellent
Language _____ Years studies _____ Speaking ability: ☐Poor ☐Fair ☐Good ☐Excellent

8 COMPLETED EDUCATION

Please indicate your highest level of completed education_____

DISCLAIMER

I understand that host countries may not be able to accommodate the restrictions or requirements indicated in the completed application and that acceptance on the GYAP program is not a guarantee that these preferences can be honoured.

_____

Candidates Signature Date

5a Health Certificate

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 question 3-9, 11-13. GYAP 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/Last) Home Country Date of Birth

1 Height _____ Weight _____ B/P _____ Pulse_____ Respiration_____

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:

	YES	NO	IF KNOWN:		YES	NO
a) Measles	☐	☐	Titer:___ Date:_____	h) Rheumatic Fever	☐	☐
b) Mumps	☐	☐	Titer:___ Date:_____	i) Cough(persistent, recurring)	☐	☐
c) Rubella	☐	☐	Titer:___ Date:_____	j) Headaches (persistent, recurring)	☐	☐
d) Chicken Pox	☐	☐		k) Sleepwalking	☐	☐
e) Poliomyelitis	☐	☐		l) Enuresis	☐	☐
f) Hepatitis	☐	☐		m) Appendicitis	☐	☐
g) Tuberculosis	☐	☐		n) Parasites(internal)	☐	☐

If yes, identify type, severity, any medication taken, name, dosage & frequency:_____

4 ACNE ☐Yes ☐No

If yes, identify type, severity, any medication taken, name, dosage & frequency:_____

5 ALLERGIES ☐Yes ☐No

If yes, identify type, severity, 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 DISEASS, IMPAIRMENT OR ABNORMALITY OF:

	YES	NO		YES	NO
a) Abdominal organs, digestive system	☐	☐	e) Heart blood vessels	☐	☐
b) Lungs, respiratory system	☐	☐	f) Tonsils nose or throat	☐	☐
c) Bones, joints, locomotor system	☐	☐	g) Blood, endocrine system	☐	☐
d) Genito-urinary system	☐	☐	h) Eyes/vision, ear/hearing	☐	☐

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:

_____

_____

_____

5b Health Certificate

_____

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 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 involved 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 GYAP 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 IMMUNISATIONS, PLEASE SPECIFY EXACT DAY, MONTH AND YEAR:

	Yes	**DAY/MO/YR**	**DAY/MO/YR**	**DAY/MO/YR**	**DAY/MO/YR**	**DAY/MO/YR**
Measles	☐	_____	_____	_____	_____	_____
Mumps	☐	_____	_____	_____	_____	_____
Rubella	☐	_____	_____	_____	_____	_____
Diphtheria	☐	_____	_____	_____	_____	_____
Pertussis	☐	_____	_____	_____	_____	_____
Tetanus	☐	_____	_____	_____	_____	_____
Poliomyelitis	☐	_____	_____	_____	_____	_____
BCG	☐	_____	_____	_____	_____	_____
Hepatitis B	☐	_____	_____	_____	_____	_____
Other	☐	_____	_____	_____	_____	_____

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 4A and 4B, 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 GYAP program.

_____

Physician Name and Degree Signature

_____

Address Date

Your signature below attests that you understand and accept the GYAP Medical Policies as stated on the Participation Agreement, that the information on Form 4A and 4B 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 GYAP program.

Candidate Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____

6. Self Permission Form

_____

Name of participant Date

_____

GYAP 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 GYAP in promotional materials. By signing this Agreement, I grant to GYAP 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 GYAP 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 GYAP to use such letters, images & audio recording or yourself.

AUTHORISATION FOR EMERGENCY MEDICAL TREATMENT

Should any medical emergency arise, if time permits, GYAP 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 GYAP, time and circumstances do not permit communication with them, I authorise GYAP to consent to medical treatment, the administration of X-ray examination, aesthetics, 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.

AUTHORISATION FOR RELEASE OF MEDICAL TREATMENT

I hereby authorise GYAP, and/or its duly authorised 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

_____

Name of emergency contact Relationship

_____

Work phone Home phone

_____

Address