Medical Evaluation Form: 2023-24 High School Study Abroad Programs

Candidate's Name: JUNG (Last) JOSHUA (First) _____ (M.I)

Program Applying for: *(Check all that apply)* ☐ NSLI-Y (Academic Year) ☒ NSLI-Y (Summer) ☐ FLEX Abroad ☐ YES Abroad

(for NSLI-Y only) **NSLI-Y Language & Duration (Preference #1):** Mandarin, Summer
(E.g., Arabic Summer)

Date of Birth: 01/29/2007 (MM/DD/YYYY) **Gender:** ☒M ☐F ☐ Other _____

PART A – CANDIDATE HEALTH SELF-ASSESSMENT (To be completed by the applicant and parent(s)/legal guardian(s))

NSLI-Y, FLEX Abroad, and YES Abroad strive 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 United States, including those for people with disabilities or related to mental health, may be limited or unavailable in the host location. Some medications may not be available, may be strictly controlled, or illegal in the host location. Disclosing information about the candidate's current health condition(s) will help program implementers determine a suitable placement. Failure to disclose medical history may result in the termination of the candidate's program scholarship. Questions about this form or accommodation for disabilities should be addressed to highschoolstudyabroad@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 another 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
5.Have you previously or are you currently experiencing any ongoing side effects related to COVID-19?	☐ Yes	☑ No
6.Do you have an immunocompromising or other condition that puts you at greater risk for COVID-19?	☐ 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/or any accommodations you may need to manage the condition(s).

_____

_____

7.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: _____

_____

_____

8.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._____

_____

9.Are you blind or do you have low vision?	☐ Yes	☑ No
10.Do you have hearing loss?	☐ Yes	☑ No
If yes, do you use a hearing aid, cochlear implant, and/or another assistive hearing device?	☐ Yes	☐ No
11.Do you have a physical or mobility related disability?	☐ Yes	☑ No

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

PART A – CANDIDATE HEALTH SELF-ASSESSMENT (Continued)

If you answered yes to questions 9, 10, or 11, please provide details and any accommodations that may be needed, as well as assistive devices used: _____

12.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.

13.Do you have any dietary restrictions or food allergies for medical reasons? ☐ Yes ☑ No
14.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. _____

15.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? _____

16.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 related to these conditions? 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. _____

17.List all over the counter or prescription medications that you take regularly or that you anticipate taking while abroad. Please explain the reason you are taking or plan to take the medication(s). If there are none, mark response as "N/A."

18.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. _____

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

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

21.Do you smoke? ☐ Yes ☑ No
If yes, will you smoke while participating in NSLI-Y/FLEX Abroad/YES Abroad? ☐ Yes ☐ No

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

PART A – CANDIDATE HEALTH SELF-ASSESSMENT (Continued) **(To be completed by the applicant and parent(s)/legal guardian(s))**

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/FLEX Abroad/YES Abroad program. The signatures below confirm that the candidate/parent(s)/legal guardian(s) will inform the programs (highschoolstudyabroad@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/FLEX Abroad/YES Abroad participants, unless otherwise required or specified by a NSLI-Y/FLEX Abroad/YES Abroad implementing organization or host location laws, are required to assume sole 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/FLEX Abroad/YES Abroad host locations may require proof of specific immunizations for entry. By signing, the candidate and parent(s)/legal guardian(s) 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 location. NSLI-Y/FLEX Abroad/YES Abroad host locations 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/FLEX Abroad/YES Abroad 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/FLEX Abroad/YES Abroad Medical Review Policies, COVID-19 Information, 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/FLEX Abroad/YES Abroad program.

At least one person who signs below must be listed in the candidate's online application as a parent or guardian. At least one parent/guardian signature is required, but signatures from all parent/guardians with legal custody are highly encouraged.

Joshua Jung — **Candidate Signature** — 01/16/2023 — **Date (mm/dd/yyyy)**

[signature] — **Parent/Legal Guardian Signature** — 01/16/2023 — **Date (mm/dd/yyyy)**

Parent/Legal Guardian Signature — **Date (mm/dd/yyyy)**

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

PART A – CANDIDATE HEALTH SELF-ASSESSMENT (Continued) **(To be completed by the applicant and parent(s)/legal guardian(s))**

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

1. The signatures below authorize American Councils for International Education and High School Study Abroad program implementing partners (collectively "the programs") 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 the programs' operations while on program to the student's parents or guardians, the programs' 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)/legal guardian(s) authorize the following protected health information (PHI), not including Sensitive Medical Records as described below, to be released: Communicable diseases (COVID-19, influenza), diagnoses/prognoses, medical histories, test results (including x-rays), records (including immunization records), reports

SENSITIVE MEDICAL RECORDS RELEASE

3. **NSLI-Y/FLEX Abroad/YES Abroad IS NOT authorized to release mental health records/information, alcohol and/or drug abuse/treatment/referral 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, the appropriate box or boxes must be checked.

4. Please refer to NSLI-Y/FLEX Abroad/YES Abroad 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)/legal guardian(s) are authorizing NSLI-Y/FLEX Abroad/YES Abroad to discuss and/or release to the candidate's parents or guardians, NSLI-Y/FLEX Abroad/YES Abroad 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
- ✓ 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 their 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 their authorization once provided, the student may send a written instruction by email to highschoolstudyabroad@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 candidate's online application as a parent or guardian. At least one parent/guardian signature is required, but signatures from all parent/guardians with legal custody are highly encouraged.

Joshua Jung — **Candidate Signature** — 01/16/2023 — **Date (mm/dd/yyyy)**

[signature] — **Parent/Legal Guardian Signature** — 01/16/2023 — **Date (mm/dd/yyyy)**

Parent/Legal Guardian Signature — **Date (mm/dd/yyyy)**

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

Candidate's Name: Jung (Last) Joshua (First) _____ (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 (telehealth or in person), and discussion with the student. Please give 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 ensure full completion of the form.. After completing this form, please return it to the student.**

1. Date of examination: 1/16/23
   MM/DD/YYYY
   Within last 3 months: Semi Finalists for NSLI-Y Academic Year/FLEX Abroad/YES Abroad
   Within last 6 months: Semi Finalists for NSLI-Y Summer ONLY

2. Type of exam: ☒ **In-Person** ☐ **Tele-health**

3. **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:

		Yes	No			Yes	No			Yes	No
3.1	Allergies to Medications/Vaccines	☐	☐	3.15	Kidney or Urinary Tract Disease (chronic or recurring)	☐	☐	3.27	Mental health condition	☐	☐
3.2	Other Allergies (including food related)	☐	☐					3.28	Learning Disability	☐	☐
3.3	Asthma	☐	☐	3.16	Vascular problems/Hypertension	☐	☐	3.29	Sexually Transmitted Diseases	☐	☐
3.4	Tuberculosis	☐	☐	3.17	Diabetes Mellitus	☐	☐	3.30	HIV/AIDS	☐	☐
3.5	Chronic/Recurrent Respiratory Disease	☐	☐	3.18	Other Endocrine Abnormality/Disease	☐	☐	3.31	Hepatitis	☐	☐
3.6	Rheumatic Fever	☐	☐	3.19	Chronic or Recurrent Arthritis	☐	☐	3.32	Severe Acne	☐	☐
3.7	Heart Disease or Abnormality	☐	☐	3.20	Muscle Disease or Skeletal Abnormality	☐	☐	3.33	Appendicitis	☐	☐
3.8	Gastrointestinal Disorder	☐	☐	3.21	Chronic or recurrent Skin Condition	☐	☐	3.34	Chicken Pox	☐	☐
3.9	Enuresis	☐	☐	3.22	Cancer or Leukemia	☐	☐	3.35	Measles	☐	☐
3.10	Persistent or Recurrent Headache	☐	☐	3.23	Vision loss/ or Eye Disease	☐	☐	3.36	Mumps	☐	☐
3.11	Migraines	☐	☐	3.24	Hearing loss	☐	☐	3.37	Rubella	☐	☐
3.12	Seizure Disorder (Epilepsy)	☐	☐	3.25	Parasites (internal)	☐	☐	3.38	Gender dysphoria	☐	☐
3.13	Other Neurological Abnormality/Disease	☐	☐	3.26	Anorexia/Bulimia/Weight Problems	☐	☐	3.39	COVID-19	☐	☐
3.14	Thyroid Abnormality/Disease	☐	☐					3.40	Other childhood disease	☐	☐

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):

Item No.	Date of most recent symptoms or attack	Incidence duration	Specific diagnosis; severity; current treatment (including medications); dosage; ongoing treatment	Current Status (active, in remission, etc.)

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

Candidate's Name: Jung (Last) Joshua (First) (M.I)

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

4. IMMUNIZATIONS. Can the student receive additional immunizations, including, but not limited to, the COVID-19 vaccine and any other vaccinations recommended by the CDC for travel to a host location? ☒ Yes ☐ No

If "No," explain: _____

An accurate and complete immunization record is required. Please specify all dates for all doses (since birth). If providing a separate print-out of the immunization record, please also answer question 4 above:

4.1 Diphtheria, Pertussis, Tetanus	DOSE 1 Date: 3/26/2007	DOSE 2 Date: 6/18/07	DOSE 3 Date: 7/30/07	DOSE 4 Date: 5/16/08	DOSE 5 Date: 3/22/201
4.2 Tdap	DOSE 1 Date: 5/31/18				
4.3 Poliomyelitis (trivalent oral or TPV)	DOSE 1 Date: 3/26/07	DOSE 2 Date: 6/18/07	DOSE 3 Date: 7/30/07	DOSE 4 Date: 3/2/11	DOSE 5 Date: / /
4.4 Measles/ Mumps/ Rubella	DOSE 1 Date: 2/14/08	DOSE 2 Date: 3/22/11	DOSE 3 Date: / /		
4.5 Hepatitis A	DOSE 1 Date: 2/14/08	DOSE 2 Date: 4/7/09			
4.6 Hepatitis B	DOSE 1 Date: 3/26/07	DOSE 2 Date: 6/18/07	DOSE 3 Date: 7/30/07	5/16/08	
4.7 Varicella/Chicken Pox	DOSE 1 Date: 2/14/08	DOSE 2 Date: 3/22/11			
4.8 Meningitis	DOSE 1 Date: 8/31/22	DOSE 2 Date: / /			
4.9 Pneumococcal	DOSE 1 Date: 3/26/07	DOSE 2 Date: 6/18/07	7/30/07	5/16/08	
4.10 Other (Typhoid, HPV, Yellow Fever, Cholera)	VACCINE 5/31/18 Date: / /	VACCINE 11/21/18 Date: / /	VACCINE Date: / /	VACCINE Date: / /	VACCINE Date: / /
4.11 Other (Typhoid, HPV, Yellow Fever, Cholera)	VACCINE Date: / /	VACCINE Date: / /	VACCINE Date: / /	VACCINE Date: / /	VACCINE Date: / /
4.12 COVID-19	VACCINE (Dose 1) Vaccine Name: Date 5/18/21	VACCINE (Dose 2) Vaccine Name: Date 6/15/21	VACCINE (Booster) Vaccine Name: Date 1/2/22	9/16/22	

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

5.1. Height 66.3" Weight 120 BMI _____ BMI Percentile _____ Blood Pressure 114/73 Pulse 82

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

5.3. Are blood pressure, pulse, or respiration abnormal? ☐ Yes ☒ No

If "Yes" to above questions, explain: _____

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

Candidate's Name: Jung (Last) Joshua (First) (M.I)

PART B – HEALTH CERTIFICATE CONTINUED

5.4. 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:

	Yes	No		Yes	No		Yes	No
5.4.a. Eyes			5.4.f. Abdomen or Abdominal Organs		✓	5.4.k. Brain or Nervous System		
5.4.b. Ears			5.4.g. Urinary System		✓	5.4.l. Skin		
5.4.c. Nose or Throat			5.4.h. Thyroid gland or Endocrine System			5.4.m. For Women: Breast, Ovaries or Genitalia		
5.4.d. Lungs or Respiratory System			5.4.i. Bones or Joints		✓	For Men: Testes or Genitalia		
5.4.e. Heart or Cardiovascular System			5.4.j. Muscles or Skeletal System			5.4.n. High Blood Pressure		

Item No.	Specific diagnosis; severity of abnormality; recommended treatment (including medications and surgery; need for follow up care)

6. *TUBERCULOSIS *Note: The programs take place in locations where the prevalence of TB is higher than in the U.S. All NSLI-Y Academic Year/FLEX Abroad/YES Abroad semifinalists must include TB test results **from the last 3 months**. If a test is submitted, the date and result from ONE (1) of the following TB tests is **required**. Question 6 is optional for semifinalists ONLY applying for NSLI-Y Summer.*

TB skin test	
Date Placed	___/___/___
Date Read	___/___/___
Result in mm	___ mm

TB IGRA Blood Test	
Date of test	11 29 2023
✓ Negative	
Indeterminate	
Borderline	

6a. (For all semifinalists) Has the candidate ever had any of the following? (Check "Yes" or "No" **for each item**):

Persistent cough	Yes	~~No~~
Weight loss	Yes	~~No~~
Abnormal chest x-ray	Yes	No N/A
Bloody sputum or any other sign or symptom of tuberculosis	Yes	~~No~~

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

7.1. Has the candidate ever been hospitalized? d/t dehydration & severe nausea @ Age 2 or 3 y.o. ✓ Yes ☐ No

7.2. Does the candidate have a medical condition that would preclude the candidate from living in a home with smokers? *(Note that smoking is more common in many program host locations than in the United States, therefore a smoke-free homestay for all candidates cannot be guaranteed.)* ☐ Yes ~~No~~ ✓

7.3. Does the candidate have any allergies and/or has the candidate tested positive for any allergies? ☐ Yes ~~No~~ ✓
If "Yes," specify the reaction and severity. ___

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

7.5. 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~~ ✓

7.6. Has the candidate ever tested positive for Celiac Disease? Never done, No indication ☐ Yes ~~No~~ ✓

7.7. Does the candidate wear glasses or contact lenses? ☐ Yes ~~No~~ ✓

Medical Evaluation Form: 2023-24 High School Study Abroad Programs

Candidate's Name: Jung (Last) Joshua (First) (M.I)

PART B – HEALTH CERTIFICATE CONTINUED

7.8. 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

7.9. 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

7.10. 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

[redacted]

8. 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 in-person or telehealth 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/FLEX Abroad/YES Abroad program.

Signature _____ Date (MM/DD/YYYY) 1/31/23

Provider Name and Qualification (MD, DO, PA, NP): Juliana Choi, CFNP

Address: _____

Phone: (703) 591-4400

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