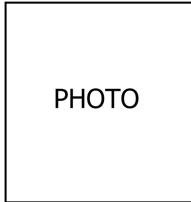

PARTICIPANT GENERAL INFORMATION

First Name: ________________________________ Last Name:_______________________________

Nickname:_____________________ Date of Birth: ________/________/__________ Age: ______
What you'd like to be called in America Month Day Year

Gender: ( ) Male Female ( ) - Height: ______ - Weight: ________ - Eye Color: _____________

Primary Language:________________________ E-mail:_______________________________________

Mailing Address: ____

City: ______________________________ State: _________________________ Zip: _____________

Country: _______________________________ Phone: (______) (______) ______________________
Country Code City Code

If participant is under 18 years old:

Father's Name: _____________________________ Phone: (______) (______) ___________________
Country Code City Code

Mother's Name: _____________________________ Phone: (______) (______) ___________________
Country Code City Code

The student would like to attend the Study/Travel Tour in: __________________________ (city)

ENGLISH EVALUATION

How many years of English study has the student completed? ____________________________

ORAL:	**Excellent**	**Good**	**Average**	**Fair**	**Poor**
Fluency	( )	( )	( )	( )	( )
Pronunciation	( )	( )	( )	( )	( )
Range of Vocabulary	( )	( )	( )	( )	( )

WRITING:	**Excellent**	**Good**	**Average**	**Fair**	**Poor**
Grammar	( )	( )	( )	( )	( )
Sentence Structure	( )	( )	( )	( )	( )
Spelling	( )	( )	( )	( )	( )

READING:	**Excellent**	**Good**	**Average**	**Fair**	**Poor**
Understanding	( )	( )	( )	( )	( )
Main Ideas	( )	( )	( )	( )	( )
Accuracy	( )	( )	( )	( )	( )

LISTENING:	**Excellent**	**Good**	**Average**	**Fair**	**Poor**
Comprehension	( )	( )	( )	( )	( )
Response Time	( )	( )	( )	( )	( )
Interaction	( )	( )	( )	( )	( )

PARTICIPANT HEALTH RECORD

Student's Name: ____ Date of Birth: _____/_____/______
Month Day Year

MEDICAL HISTORY

Any Disorders/Conditions/Surgeries ____

Please give detailed information regarding medical history: ________________________________

____

____

Are your immunizations current: ( ) Yes No ( ) Any Handicap:_________________________

Does the applicant take any medication? ( ) No Yes ( ), Name: _________________________

What is the purpose of this medication? ____

____

How often is this medication administered? ____

Any allergies (food, medication, etc.)? ____

MEDICAL RELEASE AUTHORIZATION

We, as parents/guardians of the undersigned participant, do hereby authorize USA, United Students Association (staff and directors), as agents of the undersigned parents/guardians, to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis, or treatment or hospital care which is deemed advisable by and is rendered under the general supervision of any licensed physician or surgeon at a medical facility. It is understood that this authorization is not given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the aforesaid agents to give specific consent to all such diagnosis, treatment, or hospital care which the physician or surgeon, in the exercise of his/her best judgment, may deem advisable.

Participant's Signature*:* ____ *Date:* _____/_____/_____

Father's/Guardian's Name: ____

Signature: ____ Date: _____/_____/_____

Mother's/Guardian's Name: ____

Signature: ____ Date: _____/_____/____