



Shannon J. Wiggs, Assistant Superintendent
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Thank you for requesting a Peninsula School District International Exchange Student application. This application must be completed in English and returned to us no later than June 1st to qualify for acceptance as an exchange student next school year. **Please note that all pages of this application must be completed and signed by the appropriate people before returning the packet to the district.** The packet of information that your agency obtains from students may duplicate some of the information that we are requesting. If the information is the same, simply attach your document to the applicable Peninsula School District form that it duplicates. The one exception is the Immunization Status form.

The following is a list of the necessary forms for a complete application:

1. Host Family Information
2. International Student Exchange Student Application
3. Washington State Certificate of Immunization Status form
This form must be completed, no duplicates will be accepted.
4. Exchange Student Medical and Dental Examination Report
5. Principal's Report
6. English Language Recommendation
7. Graduation / Diploma Information
8. Traffic Safety Education
9. Official transcript of your grades

Thank you for your cooperation. Peninsula School District is eager to make your exchange experience as educational, exciting and rewarding as possible.

If you have questions or need assistance, please contact Roxann Tallman by calling (253) 530-1007.





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Host Family Information

Host Family Name: _____

Address: _____

Home Phone Number (including area code): _____

Cell Phone Number (including area code): _____

Work Phone Number (including area code): _____ for _____

Place of Employment: _____

Work Phone Number (including area code): _____ for _____

Place of Employment: _____

Exchange Student's Name: _____

Exchange Student's Home Country: _____

Resident Area High School: _____





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International Student Exchange Student Application

Name: _____ Gender: _____

Address: _____

Date of Birth: _____ Place of Birth: _____
(Month/Day/Year) (City, State, Country)

Citizen of: _____

Do you have any dietary restrictions? Yes / No - If yes, explain:

Parents or Legal Guardians:

Father's Name: _____

Mother's Name: _____

Address: _____

Address: _____

Home Telephone: _____

Home Phone: _____

Occupation: _____

Occupation: _____

Business Phone: _____

Business Phone: _____

Emergency Phone: _____

Emergency Phone: _____



Personal Background:

Do you smoke? ____ Do you drink alcoholic beverages? ____
Do you use drugs? ____

What recreation/hobbies do you have and what time do you devote to them?

What other information can you give to enable a better assessment to be made of your potential as an "ambassador" for your country? (achievements, awards, talents, etc.)

School Activities:

Name and address of your school:

Number of students at your school: _____ Number of grades: _____

When will you complete high school: _____ How many years in high school: _____

What languages have you studied and for how long? Are you able to speak and read those languages, and how well:

What responsibilities have you had at school (clubs, offices, etc.):

Sporting and cultural activities (describing degree of ability in each):

Signature of Applicant: _____

Date: _____

IF THIS INFORMATION IS PROVIDED ELSEWHERE IN YOUR APPLICATION PACKET, PLEASE ATTACH.

**Peninsula School District
Exchange Student Medical and Dental Examination Report**

Name of Applicant: _____ Gender: _____

Address: _____

Telephone Number: _____

Explanation: A year in the United States for young person most often is exciting and broadening, but it can also be emotionally and physically distressing at times. Because of our concern that the chosen youth be able to succeed, we ask for your thoughtfulness in completing this examination, as authorized by the parents and applicant.

Part A (To be completed by the dental examiner)

This needs to be signed by the family dentist indicating the state of dentition, and noting any dental problem which may occur during absence in the United States and which may require attention while the applicant is abroad.

Does the applicant have any dental problems at present? _____

Is dental work required at this time? _____

Do you foresee any dental problems during applicants planned stay abroad? _____

If any answers are "Yes", please explain: _____

Signed: _____ Date: _____

Type dentist's name here: _____

Address: _____

_____ Telephone: _____

Part B (Declaration by applicant)

1. Have you or has any member of your family ever had any serious illness or surgical operations? If so, give details _____

2. Have you or has any member of your family ever suffered from been suspected of suffering from tuberculosis? If so, give details _____

3. Have you or has any member of your family ever suffered from a mental disease, fits of epilepsy, or been treated in an institution for any kind of these diseases? If so, give details _____

4. What medical attention have you required during the last twelve months? _____

5. We hereby authorize the release of medical information acquired in the course of examination by the undersigned physician. (To be signed in the presence of a medical examiner).

(Signature of parent/guardian)

(Signature of applicant)

EXAMINATION RESULTS

Part C (To be completed by the medical examiner who should state if "Normal.")

Any disability should be noted and commented upon under "Remarks" showing whether it is of a temporary or permanent nature and if it is major or minor degree.

- | | |
|------------------------------------|--|
| 1. Heart _____ | 10. Sight _____ |
| 2. Blood type _____ | (a) without glasses R _____ L _____ |
| 3. Lungs _____ | (b) with glasses R _____ L _____ |
| 4. Nervous system _____ | 11. Genito urinary organs _____ |
| 5. Mental condition _____ | 12. Urine – Is albumen of sugar present? _____ |
| 6. Digestive organs _____ | _____ |
| 7. Skeleton-bones and joints _____ | 13. Height _____ |
| 8. Skin _____ | 14. Weight _____ |
| 9. Hearing _____ | 15. Blood pressure _____ |

HEALTH HISTORY

I certify that the applicant has had or was immunized against the marked diseases on the date indicated:

_____ Chickenpox	_____ Measles (Rubeola)	_____ German Measles (Rubella)
_____ Mumps	_____ Polio	_____ Diphtheria
_____ Tetanus	_____ Whooping cough	_____ TB test

Check any of the following which are special problems and explain:

Allergies:	Chronic/Recurring Illness:	General:
_____ Hay Fever	_____ Ear infections	_____ Fainting
_____ Asthma	_____ Heart disease	_____ Sleep disturbances
_____ Drugs	_____ Convulsions	_____ Bed wetting
_____ Insect stings	_____ Diabetes	_____ Menstruation
_____ Poison ivy, oak, etc.	_____ Behavior	_____ Constipation
_____ Food	_____ Nephritis	_____ Other
_____ Other	_____ Epilepsy	
	_____ Other	

Suggestions from parents: _____

Medical examiner's remarks: _____

I CERTIFY that I have this day examined the above named, that the results are set forth, and in my opinion:
_____ subject to any special observations under "Remarks," the above named is in good health and of sound constitution and not suffering from any mental or physical defect which would preclude his/her participation in this program.
_____ the above named suffers a mental or physical defect as noted and is NOT in good health.

Signed: _____ Date: _____

Type the doctor's name here: _____

Address: _____

_____ Telephone: _____



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Principal's Report

Name of applicant: _____

Name of applicant's present school: _____

School Address: _____

Telephone (including area code): _____

Name of Principal: _____

Please state applicant's present year in school: _____

Approximate place in class: _____ out of a total number in class: _____

List subjects studied with brief comments on ability, application, etc.

Comment briefly on applicant's suitability for this exchange program and as an "ambassador" for his/her country:

Signature: _____ Date: _____

Position: _____ Telephone: _____





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English Language Recommendation

To be completed by student's English teacher

Student's Name: _____

Teacher's Name: _____

How many years has this student been enrolled in English? _____

Describe the student's ability to understand and speak English:

What problems might this student encounter with the basic English vocabulary?

What is this student's grade for English? _____

Comments: _____

Signature: _____ Date: _____





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Graduation / Diploma Information

The goal of the Peninsula School District is to offer its exchange students a sound educational program and exciting cultural experience. The normal sequence for meeting Washington State graduation requirements requires four years of study. Exchange students are not likely to have taken the classes required for Washington State graduation requirements. Therefore a foreign exchange student should not expect to receive a high school diploma. A senior student who successfully completes his/her studies will be allowed to participate in graduation ceremonies, but will receive a Certificate of Attendance, not a diploma.


I understand that a Washington State high school diploma is awarded only upon successful completion of requirements. I understand that the normal sequence for meeting these requirements is four years and that I will not meet them during my one-year exchange. I accept the condition that if I am a senior student who successfully completes the year of study, I will be allowed to participate in graduation ceremonies and will receive a CERTIFICATE of ATTENDANCE, not a high school diploma.

Student

Parent

Exchange Organization Representative

Host Parent





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Traffic Safety Education

Peninsula School District offers a three-phase Traffic Safety Education Program: classroom, simulators and behind-the-wheel instruction. During the semester a student spends about 78 hours in the classroom, 12 hours in the simulator and 4 hours behind-the-wheel driving. It is important that these three phases be integrated. For a student to do well in the behind-the-wheel phase, the student must receive additional driving time to master the skills. This is where the host parent is involved. If you take your student out and allow him/her to practice driving, you will greatly increase the student's driving skills. It is recommended that a student drive an additional 10 - 15 hours with the host parent. Some students require more time, and some require less. Before the exchange student and host parent do any of the above, it is important that the student has a driver's permit and the host parent's insurance company has been notified. Some insurance companies may not accept exchange students, others treat them the same as any other member of the family. Some companies impose a fee for coverage under a permit, while others charge only after the license has been earned. It is important to realize that the exchange student may not be allowed to participate in the Traffic Safety Education Program. It will only be by permission of the parent, host family, and insurance company.

I understand the above conditions of the Traffic Safety Education Program and understand that my son/daughter may not be allowed to participate.

I do ____/do not ____ give my permission for my son/daughter to participate if possible.

Parent's Signature: _____ Date: _____

I understand the above conditions of the Traffic Safety Education Program.

I will ____/will not ____ be able to meet the conditions for our exchange student's participation.

Host Parent's Signature: _____ Date: _____

I understand the above conditions of the Traffic Safety Education Program and that I may not be allowed to participate.

Student's Signature: _____ Date: _____

The host organization does ____/does not ____ allow exchange students to participate in Traffic Safety Education.

Area Representative's Signature: _____ Date: _____





2010-11
IMMUNIZATION REQUIREMENTS
GRADES 6 – 12

(***Grades 6, 7, 8, and 9 – see below**)
(****Grade 6 – see below**)

Washington State Law (RCW 28A.210.060-170) requires that all children have a completed Certificate of Immunization Status (CIS) on file at the school they attend AT THE TIME OF REGISTRATION.

The exact date (month/day/year) each vaccine dose was given is required.

STUDENT CANNOT ATTEND SCHOOL UNTIL THE IMMUNIZATION REQUIREMENTS ARE MET.

This law requires proof of one of the following:

1. Full immunization consisting of
 - 3 doses Hep B (Hepatitis B) or
2 doses Hep B if both doses given between the ages of 11-15 years and at least 4 months apart
 - 3 doses DTaP/DTP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis), with last dose on or after 4th birthday
 - 4 doses IPV or OPV (Polio), if all doses given before 4th birthday
3 doses IPV or OPV (Polio), if last dose given on or after 4th birthday
 - 2 doses MMR (Measles, Mumps, Rubella), first dose given on or after 1st birthday and second dose at least 28 days after the first dose

***Grades 6, 7, 8, and 9 must also have received the following:**

- **1 dose Tdap, on or after 11th birthday, if it has been at least 5 years since DTaP, DT or Td**

****Grade 6 must also have received the following:**

- **1 dose Varicella (Chickenpox), given on or after 1st birthday, or parent reported history of disease**

2. The initiation of and compliance with a schedule of immunization documented on the Certificate of Immunization Status (CIS) and signed by the parent/guardian.
3. A Certificate of Exemption (COE) completed and signed by parent/guardian for personal/philosophical or religious exemption.
4. A Certificate of Exemption (COE) completed and signed by the health care provider for medical exemption.

Reviewed by: _____

Staff Signature

Date: _____

Is there an accompanying signed Certificate of Exemption on file?

Yes No



DOH 348-013
Rev: 10/15/08

Certificate of Immunization Status (CIS)

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:		Child's Sex:	
Parent/Guardian Name:		Parent/Guardian Day Phone:	

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age	
◆ Hepatitis B (Hep B)				● Pneumococcal (PCV, PPV)				Hepatitis A (Hep A)				
	1				1				1			
	2				2				2			
	3				3							
					4							
Hepatitis B (Hep B) Alternate schedule for teens				◆ Polio (IPV, OPV)				Meningococcal (MCV4, MPSV4)				
	1				1				1			
	2				2							
Rotavirus					3			Human Papillomavirus (HPV)				
	1				4				1			
	2			Influenza (most recent)					2			
	3								3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				◆ Measles, Mumps, Rubella (MMR)				Other				
	1				1							
	2				2							
	3			◆ Varicella (chickenpox)				I certify that the information provided here is correct and verifiable.				
	4				1							
	5				2							
◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)												
	1											
	2			▼ Verification of varicella disease history ▼				Signature of Parent or Guardian _____ Date _____				
				<input type="checkbox"/> Health Care Provider (HCP) Verified ▶	<input type="checkbox"/> Signed note from HCP attached or	<input type="checkbox"/> HCP provider signature here: ▶		Licensed HCP Signature (MD, DO, ND, PA, ARNP) _____ Date _____				
				<input type="checkbox"/> HCP Verified by Registry ▶	No HCP Sig required if box at left checked.	If school staff find verification in the Registry, then school staff must: ▶		Either initial with parent approval or get parent signature below:				
				<input type="checkbox"/> Parental Report ▶	ONLY acceptable for some grades. Write date or age child had disease:				Staff initials indicating parent approval: _____			
See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.								Parent Signature indicating approval: _____				

Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

Diphtheria
 Hepatitis A
 Hepatitis B
 Hib
 Measles
 Mumps
 Polio
 Rubella
 Tetanus
 Varicella

Other (list): _____ lab report(s) attached (required)

X

Typed or Printed Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X

Signature of Licensed Health Care Provider (required)

Date (required)

Vaccine Trade Names*

Read down and across - Trade Names are in Alphabetical Order.

Trade Name	Vaccine	Trade Name	Vaccine
Acel-Imune	DTaP	Menomune	MPSV4
ActHIB	Hib	OmniHIB	Hib
Adacel	Tdap	Pediarix	DTaP + IPV + Hep B
Boostrix	Tdap	PedvaxHIB	Hib
Certiva	HPV	Pentacel	DTaP + IPV + Hib
Comvax	Hib + Hep B	Pentavalente	DTaP + Hep B + Hib
Daptacel	DTaP	Pneumovax	PPV23
Decavac	Td	Prennar	PCV or PCV7
Engerix-B	Hep B	ProHIBiT	Hib
Fluarix	Flu	ProQuad	MMRV
FluMist	Flu	Quadracel	DTaP + IPV
Fluvirin	Flu	Recombivax	Hep B
Fluzone	Flu	Rotarix	Rotavirus
Gardasil	HPV	RotaTeq	Rotavirus
Havrix	Hep A	Tetramune	DTP + Hib
HibTITER	Hib	TriHIBit	DTaP + Hib
HyperTET	TIG	Tri-Immunol	DTP
HyperHEP B	HBIG	Tripedia	DTaP
Ipov	IPV	Twinrix	Hep B + Hep A
Infanrix	DTaP	Vaqta	Hep A
Kinrix	DTaP + IPV	Varivax	Varicella
Menactra	MCV4		

Vaccine Abbreviations*

Read down - Abbreviations are in Alphabetical Order.

Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus
DTaP	Diphtheria, Tetanus, acellular Pertussis
DTP	Diphtheria, Tetanus, Pertussis
Flu (TIV or LAIV)	Influenza
HBIG	Hepatitis B Immune Globulin
Hep A (HAV)	Hepatitis A
Hep B (HBV)	Hepatitis B
Hib	<i>Haemophilus influenzae</i> type b
HPV	Human Papillomavirus
IPV	Inactivated Poliovirus Vaccine
MCV4	Meningococcal Conjugate Vaccine
MPSV4	Meningococcal Polysaccharide Vaccine
MMR	Measles, Mumps, Rubella
MMRV	Measles, Mumps, Rubella, Varicella
OPV	Oral Poliovirus vaccine
PCV or PCV7	Pneumococcal Conjugate Vaccine
PPV23	Pneumococcal Polysaccharide Vaccine
Rota (RV1 or RV5)	Rotavirus
Td	Tetanus, Diphtheria
Tdap	Tetanus, Diphtheria, acellular Pertussis
TIG	Tetanus immune globulin
VAR or VZV	Varicella

*These lists may not be comprehensive; visit <http://www.doh.wa.gov/cfh/immunize/forms/default.htm> for updated lists.