Network Exchange Application
Sacred Heart Greenwich

STUDENT APPLICATION

Please **type** the application, print out, sign and initial all areas.

Last name: _____ First name: _____

Year in school: _____ Birthdate: _____

Home Address: _____

_____

Student email address: _____ Student home email: _____

Religious Affiliation: _____

Father's name: _____ Mother's name: _____

Address: _____ Address: _____

Student lives with: _____

Father's occupation: _____ Mother's occupation: _____

Father's cell phone:_____ Mother's cell phone: _____

Father's email address: _____ Mother's email address: _____

Names, ages of siblings: _____

Sacred Heart Schools wanted for Exchange experience:

First Choice:

_____

Second Choice:

_____

Third Choice:

_____

Check your preferred living accommodations:

- Boarding student: _____
- Host Family: _____
- Relative or Family Friend: _____

If family friend, list name, address and telephone:

_____

When would you like to go on exchange? Be specific and list length of time.

How do you commute to school each day, car, bus (if bus, what bus?), carpool? List the details of your transportation.

I acknowledge that there may be additional costs associated with exchange such as boarding fees, special activities and spending money and I am willing to incur those costs. Initial here: _____

Has any of your family been involved in the exchange program? If so, in what capacity?

I acknowledge that The Network Exchange program is reciprocal and my family is willing to host an exchange student if I live with a host family during my exchange experience. Initial here: _____

Specify any allergies, physical limitations, medications, or other information that should be known by the host family or host school. List if you are allergic to any animals.

Specify any family pets that will be in the house.

Please obtain parent and student signatures for your application:

Student _____ Date: _____

Parent: _____ Date: _____

Upper School Head: _____ Date: _____

Network Exchange Coordinator _____ Date: _____

*If the exchange is during the school year and not a vacation or summer, the student is responsible for contacting the teachers before the exchange, letting them know the dates of her exchange. Also, and while on exchange, the students must communicate with the teachers for necessary work to complete during the exchange. Please include your initials here: _____

*Please answer the following questions on a separate paper, and in essay format. Pleas, limit your response to one page.

- Stay the reasons why you want to be a Sacred Heart Exchange Student?
- Refer to any experience that you might have had living away from home.
- Describe your hobbies and interests.
- What responsibilities do you have at home? Be specific.
- Have you ever held a job? If so, describe briefly

Attach a portrait of yourself, as well as a photo with you and your parents and siblings.

School Sponsored Trip Agreement

Network Exchange Trips

The details of this trip and/or activity have been explained to us by the Network Exchange Coordinator. We understand and are aware that there are certain risks involved while traveling to and from and participating in this activity. We agree to release and hold harmless Sacred Heart Greenwich for any claims, liabilities, damages, or suits which may emanate from circumstances and/or activities beyond the control of Sacred Heart Greenwich, its employees, agents, or representatives.

I give permission for _____ to participate in this activity and understand that all school rules and policies are in effect during this exchange.

Parent/Guardian Signature_____

Parent/Guardian Phone_____

Date _____

This form must be completed and turned in with the exchange application, medical forms and travel permission.

NAME OF HOST FAMILY

_____

GRADE OF HOST STUDENT

_____

AUTHORIZATION OF INTERVENTION IN CASE OF ACCIDENT OF ILLNESS

Please print this document, fill it out and return signed to your exchange coordinator in a timely manner. This document must be in the hands of the visiting school two weeks before your child's arrival.

I, undersigned ……, residing:
Home address: ……
……

Please, check one or all

○ authorize, ... , Headmaster/Headmistress of the hosting school to **follow the medical advice of a doctor** in case of accident or urgent/indispensable intervention for my child ..... born (date) ..... during his/her entire stay in the school.

○ authorize, ... , host-parents to **follow the medical advice of a doctor** in case of accident or urgent/indispensable intervention for my child ..... born (date) ..... during his/her entire stay in the family.

○ request to be called immediately before any decision is made regarding my child's health:

Family phone numbers:
Home 1:_____
Home 2: _____
Work father: _____
Work mother: _____
Cell father: _____
Cell mother: _____

E-mails:
Father: _____
Mother: _____

Parents/Guardians signature:

NAME OF HOST FAMILY

_____

GRADE OF HOST STUDENT

_____

AUTHORIZATION TO GO OUT AND TRAVEL

Please print this document, fill it out and return signed to your exchange coordinator in a timely manner. This document must be in the hands of the visiting school two weeks before your child's arrival.

To whom it may concern (host parents, faculty, administration of visited school):

- I authorize my child .... to participate to outings / field trips / travels organized by the school or by my child's host-family.
- I authorize him/her to leave the school or arrive at school after or before school hours:
  - by herself.
  - only with an adult or with a friend or a classmate but not by herself.

Parents/Guardians signature:

Student's signature:

NAME OF HOST FAMILY

_____

GRADE OF HOST STUDENT

_____

STUDENT'S MEDICAL FORM = CONFIDENTIAL INFORMATION

Please **print** this document and make sure all sections are completed in detail as clearly as possible.

Student's name: .....

Date of birth: .....

Phone numbers:

Home:..... Cell mother: ..... Cell father: .....

Health Insurer for International Travel: :.....

Contact details: .....Policy number: ..... .

(photocopy of insurance card or insurance certificate)

Required Vaccinations

Students may NOT attend without the following:

Name	Dates
1. DPT Diphtheria/Pertussis (*coqueluche*) / Tetanus combines in one vaccine booster required if greater than 4 years since last pertussis vaccination	
Or 1 Diphtheria (if injected separately)	
Or + 1 Pertussis (if injected separately)	
Or + 1 Tetanus (if injected separately)	
1 Poliomyelitis	
1 MMR (*ROR*) o 1 *each* of Mumps, Measles and Rubella	
1 or more of the Hepatitis B	
1 Varicella (chickenpox) not required when documentation provided that student had the disease	

Documentation that the student is free from TB (tuberculosis) is required for students visiting The Convent of the Sacred Heart in New York. The PPD Mantoux is the only accepted form of screening. ***Screening test must have been done by a doctor within* one *year of date of the visit*.** Students may NOT attend the school without this test.

Tuberculin Skin Test (*PPD – Mantoux ONLY*):

Date planted _____ Date read: _____ Result _____mm

History of BCG vaccine: (Does ***not*** exclude PPD testing) YES NO Date _____

Chest X-Ray: Mandatory for results 10 mm or greater and/or history of TB/BCG vaccine

X- Ray Date _____ Result: _ NEGATIVE _ POSITIVE

Medication _____

Medication Started _____ Medication Completed _____

Has your child suffered any form of asthma? Yes _ No _ If yes complete the special Asthma form below.
Has your child suffered any form of allergy? Yes _ No _ If yes complete the special Allergy form below.

Does your child have any of the following conditions?

Phobias	Yes _ No _	Heart condition of any kind	Yes _ No _
Diabetes	Yes _ No _	Migraine headaches	Yes _ No _
Epilepsy	Yes _ No _	Sight disorder	Yes _ No _
Bleeding Disorder	Yes _ No _	Psychological condition	Yes _ No _

Has your child suffered any serious injuries in the last 12 months? Yes _ No _
Your child is currently/regularly on any medications. Yes _ No _
If yes, provide details:.....
.....
.....

Medication Permission

For the relief of minor discomfort, do you give permission for your child to be given?

Medication		For symptoms of
Ibuprofen: Advil / Motrin	Yes _ No _	General pain *associated with* headache, toothache, orthodontics, injury, menstrual cramps fever of > 100.5°F or 38or 38°C
Acetaminophen / Paracetamol: Tylenol / Doliprane	Yes _ No _	General pain *associated with* headache, toothache, orthodontics, injury, menstrual cramps, fever of > 100.5°F or 38°C
Antacid: Tums / Rennie	Yes _ No _	Indigestion, acid reflux
Diphenhydramine: Benadryl	Yes _ No _	Symptoms Associated with ***Allergic Reaction*** *Only.* Hives, Rash, Anaphylaxis

Date: **Parent/guarding Signature**:

Stamp from the doctor's office: **Doctor's signature:**

All the above documents must be submitted to the visiting school at least two weeks prior to the traveling student's arrival.
Make sure to give the above documents to your exchange coordinator in a timely manner.

CONFIDENTIAL INFORMATION **Please complete ALL questions 1 - 8**

Asthma Management Form – Student

Name:
1. Usual maintenance medical program followed by the asthmatic:
2. Medication and treatment to be used during an emergency asthma attack:
3. List any known asthma trigger factor experienced by the asthmatic:

"KEY QUESTIONS"

4. Has asthma interfered with participation in normal physical activities in the past 12 months?	YES	NO
5. Has the participant been admitted to hospital due to asthma in the past 12 months?	YES	NO
6. Has the participant been on oral cortisone for asthma within the past 12 months (ex. Prednisone, Cortisone etc.)?	YES	NO
7. Has the participant suffered sudden severe asthma attacks requiring hospitalization in the Past 12 months	YES	NO
8. Does the participant require the use of a nebulizing pump as a part of their regular or emergency asthma treatment?	YES	NO
ANY RELEVANT DETAILS:		

IM PO RTA NT NOTES:

I declare that the information provided on this form is accurate and complete. I give permission for Sacred Heart Greenwich and host family to pass this information to a third party (ex: Doctor, Hospital) to facilitate the medical treatment of my child.

Parent's name _____ Signature _____

Date _____

CONFIDENTIAL INFORMATION **Please complete ALL questions 1 - 10**

Allergenic Reaction Management Form - Student

If necessary, seek the advice of your doctor when completing this form.

A DOUBLE DOSE OF ALL MEDICATION REQUIRED FOR THE PARTICIPANT'S ALLERGIC REACTION, MUST BE BROUGHT ON EXCHANGE AND NOTED ON THEIR MEDICAL FORM.

Name
1. What is the student allergic to?
2. What are signs and symptoms of the participant's reaction?
3. What medication does the student take (if any) for their allergic reaction?

Historically, my has child has suffered from:	*Mark all the appropriate boxes*
4. a **localized** reaction (rash, itching, swelling at the site the poison/irritant enters)	*Yes* _ *No* _
5. a **systemic** reaction (rash, itching, swelling away from at the site that poison/irritant enters)	*Yes* _ *No* _
6. an **anaphylactic** reaction (severe breathing problem, total body swell, emergency situation)	*Yes* _ *No* _

"KEY QUESTIONS"

7. Have allergies interfered with participation in normal physical activities within the past year?	YES	NO
8. Has the participant been admitted to hospital due to allergies in the past 12 months?	YES	NO
9. Is there a history of anaphylaxis in the person's family?	YES	NO
10. Does the person take adrenaline (Epipen) when suffering from an allergic reaction?	YES	NO

IMPORTANT NOTES:

I DECLARE THAT THE INFORMATION PROVIDED ON THIS FORM IS COMPLETE AND CORRECT. I FURTHER DECLARE IF MY CHILD IS UNABLE TO SELF ADMINISTER SUPPLIED MEDICATION. I GIVE PERMISSION FOR THE NOMINATED PERSON (Sacred Heart Greenwich staff member or Host family member) TO ADMINISTER THE SUPPLIED EMERGENCY MEDICATION.
I give permission for Sacred Heart Greenwich and host family to pass this information to a third party (ex: Doctor, Hospital) to facilitate the medical treatment of my child. I give permission to Sacred Heart Greenwich to retain this form in their archival program information, nothing I can access it at any time.

Parent's name _____ Signature _____

Date _____