



a non-profit educational organization

World Youth Service Society

ACADEMIC HIGH SCHOOL PROGRAMME

STUDENT APPLICATION

Student Name: _____

First choice of destination: _____

Second choice of destination: _____

(FOR OFFICE USE ONLY)

Student Name: _____
(Last Name) (First Name)

Student Code: _____ Nationality: _____

Date of Acceptance: _____

ACADEMIC HIGH SCHOOL PROGRAMME

STUDENT QUESTIONNAIRE

PART A

YOUR HOST FAMILY NEEDS TO KNOW A GREAT DEAL ABOUT YOU. THE FOLLOWING QUESTIONS HAVE BEEN DESIGNED TO HELP THEM DECIDE TO HOST. PLEASE ANSWER THE QUESTIONS IN DETAIL, COMPLETELY AND HONESTLY. MISUNDERSTANDINGS CAN OCCUR LATER IF THE STUDENT FAILS TO GIVE HIS HOST FAMILY FULL INFORMATION ON THESE QUESTIONS-THANK YOU.

A) LET'S GET ACQUAINTED:

1. PLEASE CHECK YOUR CHARACTER WHICH MOST DESCRIBE YOU.

- | | | | |
|--------------------------------------|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Responsible | <input type="checkbox"/> Polite | <input type="checkbox"/> Quick-tempered | <input type="checkbox"/> Active |
| <input type="checkbox"/> Adaptable | <input type="checkbox"/> Serious | <input type="checkbox"/> Shy | <input type="checkbox"/> Patient |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Formal | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Open | <input type="checkbox"/> Emotional | <input type="checkbox"/> Quiet | <input type="checkbox"/> Spontaneous |
| <input type="checkbox"/> Casual | <input type="checkbox"/> Insecure | <input type="checkbox"/> Calm | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Neat | <input type="checkbox"/> Dependent | <input type="checkbox"/> Traditional | <input type="checkbox"/> Informal |

2. PLEASE CHECK ALL ACTIVITIES YOU ENJOY.

- | | | |
|---|--|---|
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Reading | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Painting, Drawing | <input type="checkbox"/> Chess |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Playing indoor games | <input type="checkbox"/> Computers |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Photography | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Drama, Theatre | <input type="checkbox"/> Sewing |
| <input type="checkbox"/> Camping | <input type="checkbox"/> Classical music | <input type="checkbox"/> Traveling |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Visiting museums | <input type="checkbox"/> Playing cards |
| <input type="checkbox"/> Fishing | <input type="checkbox"/> Going to the symphony | <input type="checkbox"/> Stamp collecting |
| <input type="checkbox"/> Hiking | <input type="checkbox"/> Going to the movies | <input type="checkbox"/> Knitting |
| <input type="checkbox"/> Horseback Riding | <input type="checkbox"/> Singing | <input type="checkbox"/> Watching sports |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Piano | Other activities: |
| <input type="checkbox"/> Wind Surfing | <input type="checkbox"/> Guitar | _____ |
| Other Sports: | <input type="checkbox"/> Dancing | _____ |
| _____ | Other arts and entertainment: | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Participating in: Social clubs() School clubs()
 Political organizations()
 Religious activities()

3. WHAT IS YOUR FAVOURITE SUBJECT? _____

4. WHAT IS YOUR LEAST FAVOURITE SUBJECT? _____

5. HAVE YOU EVER LIVED OR TRAVELLED OUTSIDE YOUR COUNTRY?
 Where and when? _____

ACADEMIC HIGH SCHOOL PROGRAMME

STUDENT QUESTIONNAIRE

PART B

6. PLEASE FILL OUT THE BLANKS UNDERLINED BELOW.

a. In the morning I wake up at (what time) _____ and leave my house for school at (what time) _____
School starts at (what time) _____ and is dismissed at (what time) _____
I belong to _____ club and spend (how long) _____ hours in this activity after school. I usually
arrive at my home by (what time) _____. I eat dinner at (what time) _____ with (who)
_____. I help my mother with (what) _____
_____ for about (how long) _____. My study hours are from _____
to _____. I generally watch TV from _____ to _____.
Other than studying and watching TV, I spend my time:
_____ for (how long) _____
_____ for (how long) _____
_____ for (how long) _____
I go to bed at _____.

b. Additional comments (include other activities or involvements which you spend time participating in
which you did not list above):

B) MORE ABOUT YOURSELF:

1. WHAT MAKES YOU HAPPY? _____

2. WHAT MAKES YOU SAD? _____

3. WHAT DO YOU LIKE BEST ABOUT YOUR SCHOOL? _____

4. HAVE YOU EVER WORKED? _____ YES, _____ NO IF YES, WHEN _____ HOW LONG? _____

WHAT TYPE OF JOB? _____

5. WHAT KIND OF PEOPLE DO YOU GET ALONG WITH BEST? _____

6. WHAT KIND OF PEOPLE DO YOU GET ALONG WITH LEAST? _____

7. WHAT DO YOU WANT TO DO IN THE FUTURE? _____

ACADEMIC HIGH SCHOOL PROGRAMME

STUDENT QUESTIONNAIRE

PART C

C) YOU IN CANADA/ENGLAND:

1. WHAT DO YOU EXPECT FROM YOUR JAPANESE FAMILY? _____

2. WHAT DO YOU EXPECT FROM YOUR JAPANESE SCHOOL? _____

3. PLEASE LIST ANY ACTIVITIES YOU WOULD ESPECIALLY LIKE TO PURSUE DURING THE PROGRAMME. _____

4. PLEASE LIST ACTIVITIES YOU WOULD ESPECIALLY LIKE TO ENJOY WITH YOUR HOST FAMILY. _____

5. PLEASE DESCRIBE WHAT YOU CAN IMPROVE THROUGH THE PROGRAMME? _____

D) ABOUT YOUR FAMILY:

1. HOW WOULD YOU DESCRIBE YOUR FATHER'S CHARACTER? _____

2. HOW WOULD YOU DESCRIBE YOUR MOTHER'S CHARACTER? _____

3. PLEASE DESCRIBE YOUR RELATIONSHIPS WITH YOUR FAMILY. _____

4. WHAT DOES YOUR FAMILY ENJOY DOING TOGETHER? _____

5. WHAT ARE THE RULES IN YOUR FAMILY? _____

6. WHAT HOUSEHOLD DUTIES DO YOU PERFORM AT HOME? _____

7. DO YOU HAVE A CURFEW? IN YOUR HOME? _____ YES, _____ NO
IF YES, WHAT TIME? _____ WEEKDAY, _____ WEEKEND

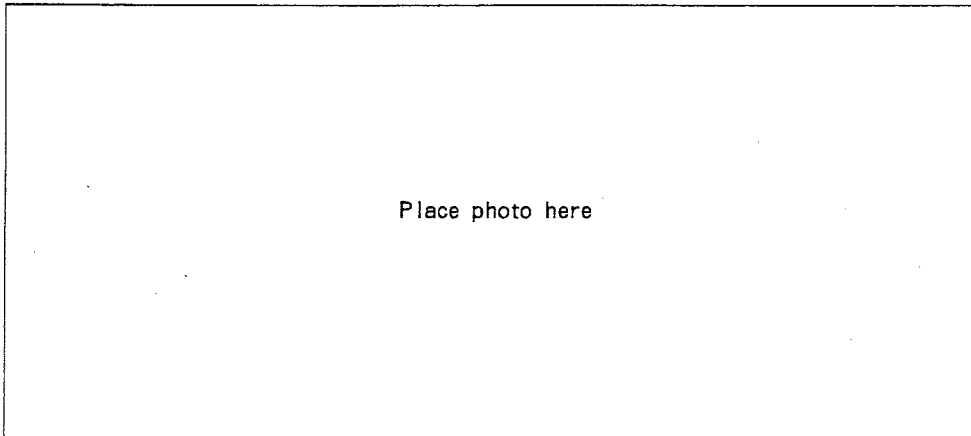
E) MEDICAL INFORMATION:

1. DO YOU HAVE ANY MEDICAL INFORMATION HOST FAMILIES NEED TO KNOW ABOUT? _____ YES, _____ NO
IF YES, PLEASE EXPLAIN _____
2. ARE YOU UNDER A DOCTORS CARE AT PRESENT? _____ YES, _____ NO
IF YES, PLEASE EXPLAIN _____
3. ARE YOU ALLERGIC TO ANYTHING? (FOR EXAMPLE: ANY FOOD OR PETS)
IF YES, PLEASE EXPLAIN _____
4. WILL YOU HAVE ANY DIFFICULTY ADJUSTING TO THE FOLLOWING?
PETS? () YES () NO
FOOD? () YES () NO
EATING SCHEDULES? () YES () NO
LIVING ARRANGEMENTS? () YES () NO
FAMILY DISCIPLINE? () YES () NO
YOUNG CHILDREN? () YES () NO
SMOKING () YES () NO
IF ANY ANSWERS OF ABOVE ITEMS ARE YES, PLEASE SPECIFY THOROUGHLY AND EXPLAIN _____
5. ARE YOU TAKING ANY MEDICATIONS? _____ YES, _____ NO
IF YES, PLEASE EXPLAIN _____

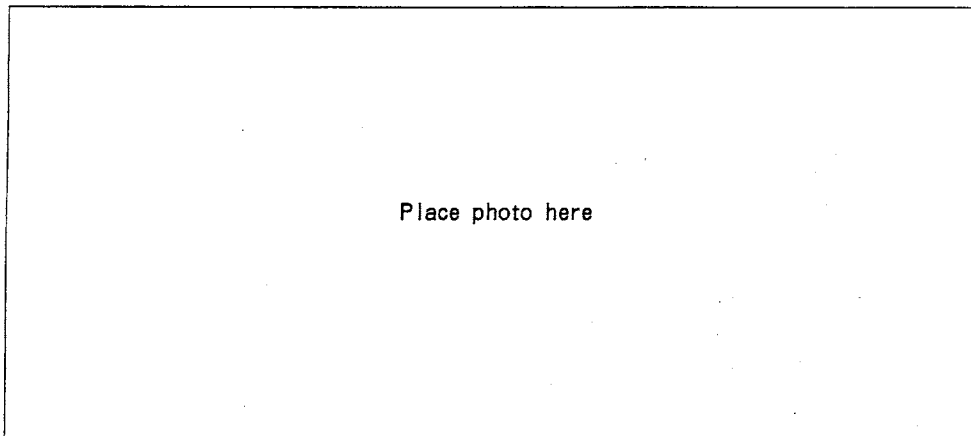
ACADEMIC HIGH SCHOOL PROGRAMME

STUDENT PHOTO ALBUM

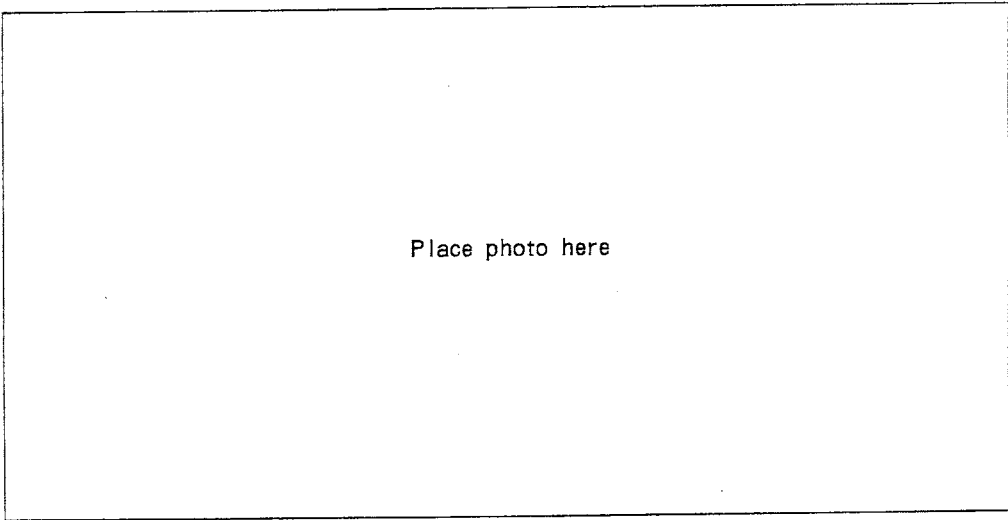
Please place photos of yourself and your family in familiar surroundings, doing the things you normally like to do. These photos are for your host family so we encourage you to include those photos which best express yourself and surroundings.



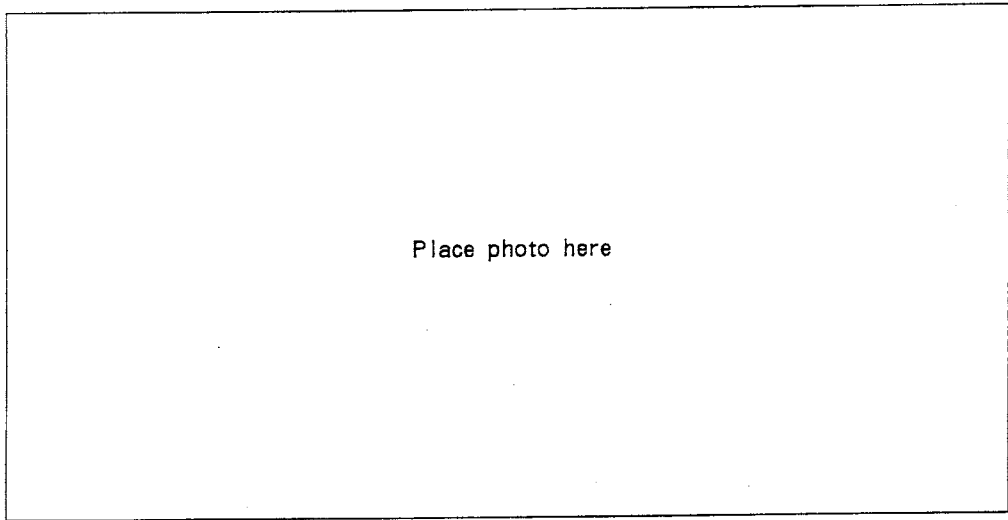
Describe photo #1 above: _____



Describe photo #2 above: _____



Describe photo #3 above: _____



Describe photo #4 above: _____

ACADEMIC HIGH SCHOOL PROGRAMME

Official Junior High School Transcript

This form must be filled out, in English, by your Junior High School Principal.

NAME OF STUDENT: _____ SEX: _____ MALE _____ FEMALE _____

DATE OF ADMISSION: _____ DATE OF GRADUATION: _____

GRADING SCALE: A/5 EXCELLENT, B/4 GOOD, C/3 AVERAGE, D/2 POOR, F/1 FAILING

S U B J E C T S	GRADE 7		GRADE 8		GRADE 9	
	Hours/Week	Grade	Hours/Week	Grade	Hours/Week	Grade
ENGLISH						
GEOGRAPHY, HISTORY, SOCIAL STUDIES						
MATHEMATICS						
SCIENCE						
FOREIGN LANGUAGE						
MUSIC						
ART						
PHYSICAL EDUCATION						
HANDICRAFT OR HOMEMAKING						
OTHERS						
GRADE POINT AVERAGE						
NUMBER OF INSTRUCTIONAL DAYS						
NUMBER OF ABSENCES						

We certify that the above statement is true.

NAME OF PRINCIPAL AND SIGNATURE

NAME OF JUNIOR HIGH SCHOOL

ADDRESS OF SCHOOL

DATE: DAY/MONTH/YEAR

OFFICIAL
SCHOOL'S STAMP
HERE

ACADEMIC HIGH SCHOOL PROGRAM

OFFICIAL HIGH SCHOOL TRANSCRIPT

NAME OF STUDENT: _____ GENDER: MALE FEMALE

DATE OF ADMISSION: _____ PRESENT GRADE: _____

« GRADING SCALE: A/5-EXCELLENT, B/4-GOOD, C/3-AVERAGE, D/2-POOR, F/1-FAILING »

SUBJECTS	GRADE 10		GRADE 11		GRADE 12	
	Credit	Grade	Credit	Grade	Credit	Grade
LANGUAGE						
SOCIAL STUDIES						
MATHEMATICS						
SCIENCE						
HEALTH & PHYSICAL EDUCATION	Physical Education					
	Health Education					
ARTS						
FOREIGN LANGUAGE	English					
Period of Integrated Study						
Total Credits						
Required Number of days to attend School						
Absent Record						

We certify that the above statement is correct in every detail.

NAME OF THE PRINCIPAL AND SIGNATURE

DATE: DAY / MONTH / YEAR

NAME OF THE HIGH SCHOOL

OFFICIAL SEAL
HERE

ACADEMIC HIGH SCHOOL PROGRAMME

Home Room Teacher's Recommendation

Name of Student: _____

How long have you known the student? _____

Please check the appropriate box below:

	E	G	F	P
MATURITY				
RESPONSIBILITY TO SELF				
RESPONSIBILITY TO OTHERS				
HONESTY				
OPENNESS				
SENSE OF HUMOUR				
CREATIVITY				
PERSONAL MOTIVATION				
ACADEMIC MOTIVATION				
ABILITY TO ADAPT TO NEW EXPERIENCES				
ABILITY TO INTERACT WITH OTHERS				
OVERALL CHARACTER				

Scale:
 E - Excellent
 G - Good
 F - Fair
 P - Poor

In the space below please give written comments on the student's character, aptitude, motivation, study habits, and attendance record.

I certify the above statement is true to the best of my knowledge.

 (Teacher's Name and Signature)

 (Date)

 (Name of School)

 (Address of School)

ACADEMIC HIGH SCHOOL PROGRAM

Japanese or English Teacher's Recommendation

NAME OF STUDENT: _____

How long have you known the student? : _____

How long have you had the student as a Japanese / an English language student? _____

Please check the appropriate box below:

	<i>E</i>	<i>G</i>	<i>F</i>	<i>P</i>
READING				
WRITING				
SPEAKING				
COMPREHENSION				

Scale:
 E – Excellent
 G – Good
 F – Fair
 P – Poor

In the space below, please give written comments in English (Japanese), on the student's Japanese or English ability, aptitude, motivation, attendance record, and study habit.

I certify the above statement is true to the best of my knowledge.

 (Teacher's name and signature)

 DATE: DAY / MONTH / YEAR

 (Name of the school)

 (Address of the school)

ACADEMIC HIGH SCHOOL PROGRAMME

PHYSICIAN'S STATEMENT OF HEALTH

PART A

DIRECTIONS: PART A must be completed by the student and his/her parents and confirmed by the examining physician. Parts B and C should be completed and signed by a physician to signify the accuracy and completeness of the information provided on this form. Please answer all questions.

Student's Name _____

Birthdate: Day / Month / Year _____

Do you now or have you ever had any of the following? If yes, give dates of illness and detailed information regarding any impairment in the space provided below.

	DATE	YES	NO		DATE	YES	NO
Chicken Pox	_____	<input type="checkbox"/>	<input type="checkbox"/>	Allergies*	_____	<input type="checkbox"/>	<input type="checkbox"/>
Measles	_____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma*	_____	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	_____	<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Poliomyelitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cough (persistent, recurring)	_____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	_____	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	_____	<input type="checkbox"/>	<input type="checkbox"/>	Enuresis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid abnormality (Struma)	_____	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	_____	<input type="checkbox"/>	<input type="checkbox"/>	Headache (persistent, recurring)	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	_____	<input type="checkbox"/>	<input type="checkbox"/>
Parasites (intestinal, other)	_____	<input type="checkbox"/>	<input type="checkbox"/>	Learning or Speech Defect	_____	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	_____	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo, Dizziness	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other (please indicate) _____	_____	<input type="checkbox"/>	<input type="checkbox"/>

*If yes, physician must attach statement describing allergy, allergen, medication sensitivity, symptoms, treatment, medications and expected future treatment.

Any disease, impairment or abnormality of any of the following:

Abdominal Organs, Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary System	<input type="checkbox"/>	<input type="checkbox"/>
Bones, Joints, Locomotor System	<input type="checkbox"/>	<input type="checkbox"/>	Heart or Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>
Blood, Endocrine System	<input type="checkbox"/>	<input type="checkbox"/>	Lungs, Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>
Brain, Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Skin (Acne, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Ears or Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils, Nose or Throat	<input type="checkbox"/>	<input type="checkbox"/>
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

Is student currently using any prescription drugs/medication? NO YES, give details: _____

Has student ever been hospitalized? NO YES

Has student ever been advised to have surgery which has not been done? NO YES

Has student ever consulted a neurologist, psychologist, any other specialist in nervous or mental disorders? NO YES

If yes to any of the above, please explain in detail: _____

PARENT OR GUARDIAN'S SIGNATURE

_____/_____/_____
DATE: DAY / MONTH / YEAR

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Provide figures for the following:

Height	Weight	Blood Pressure	Hemoglobin	Urinalysis SP.GR.	Blood Group
ALBUMIN	Sugar	Vision without glasses OD OS		Stool	Rh Factor

Are pupillary and knee reflexes normal? _____

Does student have any scars or identifying marks? If yes, please describe. _____

YES NO

Are there any restrictions on the student's participation in Physical education and/or sports activities? _____

YES NO

Describe in detail, each disease, impairment or abnormality not fully explained on either side of this form.

If the student wears glasses or contact lenses, please complete the following ophthalmic information.

	Sphere	Cylinder	Axis	Prism	Base
(OD) Ocular Dexter					
(OS) Ocular Sinister					

Add _____ Base Curve _____

Other _____

Give your opinion of the general state of the candidate's health.

Excellent Good Fair Poor

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the candidate and certify that all important medical information has been included and that the above information is accurate.

Physician's Name (type or print)

Address

Physician's Signature

Date

OFFICIAL PHYSICIAN'S STAMP HERE

ACADEMIC HIGH SCHOOL PROGRAM IMMUNIZATION RECORD

NAME OF STUDENT: _____ Gender: _____ Date of Birth: _____
Last First Day / Month / Year

VACCINE	DATE EACH DOSE WAS GIVEN				
	1 ST	2 ND	3 RD	4 TH	5 TH
POLIO MYELITIS	Mo / Year /	Mo / Year /	Mo / Year /	Mo / Year /	Mo / Year /
DTP and/or TD <small>(Diphtheria, Tetanus and Pertussis or Whooping cough) or (Tetanus and Diphtheria only)</small>	/	/	/	Mo / Year /	Mo / Year /
MEASLES <small>(Rubeola – 10 day, red measles)</small>	/	IF NO IMMUNIZATION GIVE DATE STUDENT HAS MEASLES			
RUBELLA <small>(German Measles – 3 day measles)</small>	/	IF NO IMMUNIZATION			
MUMPS	/	Recommended but not mandatory			

IMMUNIZATIONS REQUIRED FOR SCHOOL ADMISSION INTO HIGH SCHOOLS IN JAPAN.

POLIO(Trivalent Oral – TOPV) _____ at least 2 doses
DIPHTERIA-TETANUS-PERTUSSIS(DPT) _____ at least 3 doses
 Or
DIPHTERIA-TETANUS (TD) only _____ at least 3 doses

MEASLES (Rubeola, 10-day-measles) _____ one dose on or after one year of age or laboratory confirmed disease verified by a physician.
RUBELLA (German measles, 3 day measles) _____ one dose on or after one year of age or laboratory confirmed disease verified by a physician.
MUMPS vaccine _____ one dose on or after one year of age is highly recommended.

TB Skin Test date: _____ Result: Negative Positive (If positive, chest X-ray must be provided).

CHEST X-RAY EXAMINATION REPORT: examination date: _____

This is to certify that the person named above received the following results from a chest X-ray:

(_____) Revealed no abnormalities / (_____) others

Comment: _____

I, the undersigned, have give a thorough physical examination and reviewed the medical history of the candidate. I certify that all important medical information has been included, and that the above information is complete and accurate.

(Physician's Signature)

(Date)

(Physician's name)

OFFICIAL
PHYSICIAN'S STAMP
HERE

ACADEMIC HIGH SCHOOL PROGRAMME

MEDICAL RELEASE AUTHORIZATION

WE, as parents of the undersigned student, do hereby authorize WYS, WYS Academic Programme Coordinator and the host parents as agents of the undersigned parents to consent to any X-ray examinations, anaesthetic, 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, whether such treatment or diagnosis is rendered at the clinic of said physician or surgeon or at a hospital

It is understood 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 our aforesaid agents to give specific consent to any and all such diagnoses, treatment or hospital care which the aforementioned physician or surgeon in the exercise of his/her best judgement may deem advisable.

This authorization shall be valid for the entire duration of the WYS program in which the student is participating.

Parent Signature

Date: Month/Day/Year

Student Signature

Date: Month/Day/Year

For WYS use only
Signature of Host Parents
Signature of Academic Programme Coordinator

ACADEMIC HIGH SCHOOL PROGRAMME

W. Y. S. RULES

Below are the WYS rules for all students. Please read carefully and sign your name after you fully understand and agree to comply with these rules.

1. WYS students must abide by the laws of JAPAN and the home country, also by rules of the host school.
2. Students must only use drugs prescribed by a doctor. (This includes all hallucinogenic drugs.)
3. Students are not permitted to purchase or drink alcoholic beverages. Students are also not permitted to smoke.
4. Students are not permitted to drive any motor vehicles; to take driver's education, nor to obtain a driver's license while participating in the WYS programme.
5. Students must not participate in any sexual contact or sexual activity that is inappropriate for minors.
6. Students are not permitted to participate in sky diving, hang gliding, parachute jumping or any other dangerous activities.
7. Students must always be aware of their responsibility as exchange students and make a determined effort in their school. Students who are expelled from high school due to poor behavior or low grades will be sent home.
8. Students must obey host family rules about such things as curfews, household chores, and computer use, etc.. Students may not have guests in the host family's home without their host parents' permission.
9. Students are not permitted to talk about the family's private affairs to others.
10. Students can not change families and schools at will.
11. Students may not make any decisions or take any action that may change the nature or course of their life, i.e. getting married, changing religion etc.
12. Students are not permitted to go on trips by themselves or hitchhike. A trip with the host family or any other responsible adult person is allowed if permission from the parents, the host parents and WYS Counselors is submitted beforehand. Students are not allowed to travel while school is in session. Visits from relatives and friends should be restricted to the end of the students programme.
Visits from relatives and friends should be restricted to the end of the students program.
13. WYS students are expected to return to their native countries at the date, which WYS specifies. WYS staff, your host family and WYS Counselors will not be responsible for you after the end of the programme.
14. Students must show their respect for their WYS Counselors and obey their instruction.

I understand that I am responsible for keeping all WYS rules. I also understand that failure to abide by the above rules may result in dismissal from the WYS Programme and termination of my student visa, and I may be sent back home at once at my own expense.

Signature of student _____ date _____

Signature of parent _____ date _____