The Reality Tour

A Journey to the Dominican Republic

Student Application

Application due to Lake or Whiteman by March 14, 2016

Essential Information

1. **PERSONAL INFORMATION**

Student:

First & Last Name:	Age and Grade:	Personal Email:
Address:	High School GPA:	Facebook Username:
Date and Place of Birth:	Cell Number:	Passport Number:

Parent or Guardian 1:

First & Last Name:	Employer:	Personal Email:
Address:	Cell Number: Home Number:	Facebook Username:

Parent or Guardian 2:

First & Last Name:	Employer:	Personal Email:
Address:	Cell Number: Home Number:	Facebook Username:

2. **SHORT ANSWER ESSAYS**

Please type your answers to the following questions on a separate document and attach to your application upon submission.

1. Discuss what do you do in your spare time? What are your interests both inside and outside of school? Include any involvement in extracurricular activities, clubs, as well as participation in projects or service that aims to help or improve our local, national, or global communities?

2. What experience do you have traveling abroad or outside of Oregon? Please explain.

3. What classes have you taken in high school and beyond that you feel have prepared you to participate in the Reality Tour? (A class connected directly by content, one that has inspired your curiosity, or has been influential in guiding your interest?) Explain. What grade did you earn in those classes?

4. Discuss the skills you bring to the group and explain your background or experience. (Foreign language, computer literacy, instruments, leadership, organization, audio, video, culinary, wordsmith, arts, crafts, woodworking, or other.)

5. Please discuss why you are interested in being a participant of the Reality Tour? What do you feel you will gain from this experience? In what way do you see the Tour as a worthy investment?

6. Briefly discuss why you would be a good candidate for participation on the Reality Tour.

3. **HEALTH INFORMATION**

Information about health-related matters is absolutely essential to enable responses to participants' needs. In order to best help and assist the concerns and needs of all participants, please provide information on each of the following questions. All information provided will be kept confidential.

MEDICAL AND MENTAL HEALTH HISTORY

Medical Information

Do you have any (or have a history) of the following conditions?

1. Yes No – Asthma requiring daily medication
2. Yes No – Seizure disorder
3. Yes No – Diabetes
4. Yes No – Any orthopedic/neurologic condition that impairs your mobility
5. Yes No – Any congenital medical condition (e.g. congenital heart disease)
6. Yes No – Hypertension
7. Yes No – Dengue Fever
8. Yes No – Altitude Sickness
9. Yes No – Food Allergy
10. Yes No – Medication Allergy
11. Yes No – Insects Allergy
12. Yes No – Seasonal Allergy (hay fever)

Have you experienced the following symptoms during an allergic reaction?

13. Yes No – Reddening of the skin, itchy skin, or hives
14. Yes No – Swollen lips or eyelids
15. Yes No – Tightness of the throat, wheezing or difficulty breathing
16. Yes No – Coughing or sneezing
17. Yes No – Vomiting or diarrhea
18. Yes No – Do you require the use of an Epi-pen for your allergies?
19. Yes No – Have you ever had to use the Epi-pen?
20. Yes No – Have you ever experienced anaphylactic shock?

Mental Health and History

Do you have a history of any of the following, even if you have not seen a mental health professional for treatment?

21. Yes No – Cutting/ Self-harm
22. Yes No – Patterns of insufficient or excessive food intake
23. Yes No – Excessive panic and/or anxiety
24. Yes No – Mood problems
25. Yes No – Unprescribed drug or excessive alcohol use
26. Yes No – Sleeping Issues
27. Yes No – Have you ever sought professional help for a psychological or behavioral problem? (ADHD, eating disorder)

Please indicate if you are currently, or in the past two years, have received any of the following services listed below.

28. Yes No – Received outpatient mental health services (e.g. therapy or counseling sessions)
29. Yes No – Received inpatient psychiatric services (e.g. hospitalization for psychiatric treatment)
30. Yes No – Received chemical dependency services.
31. Yes No – Received treatment in an eating disorder program

Mental Health Medications

32. Yes No – Are you currently, or have you within the past two years, taken prescribed medication for a psychological or behavioral problem?

MEDICAL AND MENTAL HEALTH DETAILS

1. Do you have a medical condition that could require attention or accommodation? If so, explain.

2. Do you take any medications regularly? If so, what medication and what is it for?

3. Do you have any allergies? To what? What must you do during an allergy attack? If so, please explain.

4. Do you have any dietary restriction? If yes, please describe in detail.

4. ADDITIONAL INFORMATION

Please add any additional information you consider important in order to best assist your needs.

By signing below I acknowledge the information provided in this application to be completely factual to the extent of my knowledge.

Date Signature of the Applicant

Date Signature of Parent of Guardian