

# Yamate Gakuin High School Exchange Program Application

First and Last Name: \_\_\_\_\_

Gender (please circle one): M / F

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

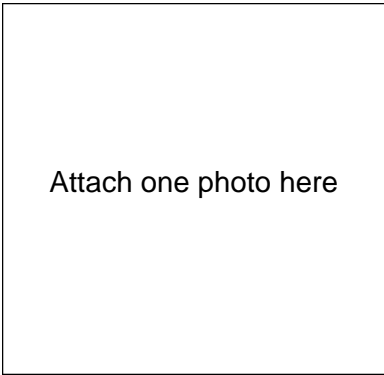
City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell: \_\_\_\_-\_\_\_\_-\_\_\_\_

High School: \_\_\_\_\_



I want to be a Student Host April 9-23, 2010

I want to travel to Japan July 21-August 4, 2010

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Father's Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

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Foods you like: \_\_\_\_\_

Foods you dislike: \_\_\_\_\_

Interests and Hobbies: \_\_\_\_\_

Favorite school subjects: \_\_\_\_\_

Religion: \_\_\_\_\_

Please list and describe any allergies you have: \_\_\_\_\_  
\_\_\_\_\_

Please list all current medical conditions: \_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

**Reference Information**

1. School Reference: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

2. School Reference: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

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Church Name: \_\_\_\_\_

Pastor's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

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***Please answer in essay form:***

1. Why do you want to travel to Japan?

2. Explain why you would be a good representative of your school and the USA in Japan.

**Please hand your application to the Yamate contact at your school or mail to our office at:  
American Home Life International, Inc. \* 1725 Oregon Pike \* Lancaster, PA 17601**

## **Release for Medical Treatment**

I hereby give permission for \_\_\_\_\_ to receive emergency medical treatment at  
(Child's Name)  
a local medical center or at any hospital or doctor American Home Life International, Inc. deems appropriate. This emergency medical treatment may include surgery, if deemed necessary by the attending physician. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned son/daughter pursuant to this authorization. Should it be necessary for my son/daughter to return home, due to medical reasons or otherwise, the undersigned shall assume all transportation costs and expenses.

I give permission for my child to receive medical attention and medication as deemed necessary by the attending physician or recognized health care provider.

We, the undersigned (parents/legal guardians) hereby release American Home Life International, Inc., its Board of Directors, Student Coordinators, Host Family Guarantors, Host Families and Academic Institutions from any and all current and future claims, charges, costs and/or causes of action for loss of property, personal injury, illness, accident or death sustained by my child during the time that he/she is participating in the program, whether covered by current insurance or not. I further agree to indemnify and hold harmless all of the above named from any and all liabilities, including liabilities to third parties, which may arise from my child's participation in the program.

### **Release for Promotion**

We, the undersigned, grant American Home Life International, Inc. permission to use photographs and any other materials in which the participant/child may appear, for promotion or publicity of future programs.

We, the parents/legal guardians, certify that all information provided in the application is correct and complete, including medical and immunization information. We understand that withholding information and/or providing incorrect information may result in termination from the program and repatriation at the parents'/legal guardians expense with no refund of fees.

### **Parent or Guardian Signature:**

Father/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required if student is under 18 years of age)

Mother/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required if student is under 18 years of age)

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Medical Insurance:**

Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_