



CITY OF PEORIA SISTER CITIES YOUNG AMBASSADOR APPLICATION

Deliver or Return by Mail to: Terri Smith
Peoria City Hall
City Council Office; 3rd Floor
8401 W. Monroe Street
Peoria, Arizona 85345

Student Information: Full Last Name: _____ First Name: _____
Address/City/ Zip: _____
E-Mail: _____ Gender: F M Age Upon Departure ____
Home Phone: _____ Cell Phone: _____
Birth Date: ___ / ___ / ___ City of Birth: _____ Country of Birth: _____

Father's Information: Last Name: _____ First Name: _____
Occupation: _____ Contact Phone: _____

Mother's Information: Last Name: _____ First Name: _____
Occupation: _____ Contact Phone: _____

Applicant lives with: ___ Both Parents ___ Mother Only ___ Father Only ___ Other

Parents are: ___ Married ___ Separated ___ Divorced ___ other

Other Family Members:	Name	Gender	Age	Relationship	Grade Level
1.	_____				
2.	_____				
3.	_____				
4.	_____				

Has any family member previously been selected as a Peoria Young Ambassador or in some other foreign exchange program? If so, when.

I. INTERESTS AND HOBBIES – This section to be completed by youth applicant

- List all school, extracurricular activities, and hobbies in which you do / have participated – most recent first

Activity	# Hours / Week	Mo./Yr. Started	Mo./Yr. Ended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- List any awards and outstanding achievements in the activities listed above

Name of Award / Achievement	Reason for Award	Year Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Have you traveled abroad? _____ If so, where and when. _____

II. FUTURE PLANS – This section to be completed by youth applicant

- Do you intend to continue your education after high school? ___ YES ___ NO

If yes, where would you like to attend school? _____

What course of study would you like to pursue? _____

- What are your future career plans? _____

III. PERSONAL DATA – This section to be completed by youth applicant

- Please provide the name (s) and telephone number (s) of responsible parties, other than your parents in the event of an emergency:

1. _____

2. _____

- What are your household responsibilities? _____

- Do you have a curfew at home: ___ YES ___ NO
If yes, what time are you expected to be at home during the week? _____ On weekends? _____

- How much time do you spend studying? _____

- Have you ever lived or traveled away from your parents? _____

- Do you work or have you ever held a Job? YES NO
If yes, please describe the type of jobs you've held, as well as when and where you worked. _____
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- Religious affiliation / Denomination _____

Religious participation: Regular Occasional Seldom

How actively would you pursue your religion if you traveled to Northern Ireland as a Young Ambassador?

Regular Occasional Seldom

- Do you smoke: YES NO (very important to answer this question honestly)

If yes, I agree not to smoke at any time during the exchange YES NO

- Are there any animals in the family home? If so, please list the types of animals. _____
-

Many host families have pets and you may be expected to adjust to living in a home with them (i.e. cats and dogs). Are there any medical concerns that the City of Peoria should be aware of regarding pets? If yes, please explain.

- Do you have any particular dietary needs (caffeine, sodium, vegetarian)? _____

IV. HOST FAMILY / PAIRING PLACEMENT – This section to be completed by youth applicant and parents

The City of Peoria and the Peoria Sister Cities Board expects each selected youth ambassador to adjust to the family and twin selected for you. It is important to understand that there is no "perfect" host family and twin. As a Young Ambassador, you should be prepared to accept the host family selected by the city and board, make every effort to become a member of the host family and to participate in all related Young Ambassador Activities.

I, the youth applicant, and my parent agree to accept the host family assignment designated for me.

Youth Applicant Signature: _____ Date: _____

Parent Signature: _____ Date: _____

V. SELF PROFILE – This portion to be completed by youth applicant

In a typewritten statement of at least 400 words, but no more than two, single-spaced pages, please respond to the following:

1. Describe yourself, your interests, and your family life
2. Describe a day in your life during the school year
3. Describe a day in your life during the summer break
4. Describe three of your character strengths

- VI. Hypothetically, as a Peoria Young Ambassador delegate to the Borough of Ards, Northern Ireland, you want to call your family in Peoria to tell them about your adventures. Assuming that you want to reach your parents in Peoria at 6:00 am at their house, what time will it be where you are calling from? Explain how you came to this conclusion
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- VII. **PARENTS' STATEMENT – This portion to be completed by parent (s)**
In a typed or handwritten letter of at least 100 words, but no more than one single-spaced page, prepare a message to the host parents that would share their home with your son or daughter during the exchange. Thoroughly communicate personality and character traits that would help the host family better understand your son or daughter.
- VIII. **FAMILY PHOTOS – This portion to be completed by youth applicant**
Please attach three to four photos showing your, your family, and your friends in places you live or frequently visit. This is a way for the host family to better understand the way you live. Please describe what is shown in the photo.
- IX. **SCHOOL TRANSCRIPT OF GRADES – This section to be completed by youth applicant**
Please attach a photocopy of the high school grade transcript that is up-to-date through the last completed semester.
- X. **PARENT / LEGAL GUARDIAN PERMISSION - This portion to be completed by parent**
My son / daughter has my permission to apply for, and to participate in if selected, the Peoria Sister Cities Young Ambassador Youth Exchange program, sponsored by the City of Peoria.

Parent / Legal Guardian Signature

Date

Printed Name

CHECKLIST OF ITEMS TO BE SUBMITTED TO BE CONSIDERED A COMPLETE APPLICATION PACKET:

1. Completed application form – all four pages
2. Self- Profile statement
3. Parents' letter to host family
4. Family photos with descriptions
5. School transcripts

APPLICATIONS ARE DUE BY DECEMBER 30 AT THE LOCATION NOTED ON THE APPLICATION COVER PAGE

Note: Please DO NOT staple the pages of the application together or place them in a report cover; simply use a binder clip or paper clip

XIII. STATEMENT OF HEALTH – To Be Completed by Parents

Student Name: _____

Birthdate: ____ / ____ / ____
 Day Month Year

- Has the student ever had any of the following? If yes, give dates of illness and detailed information regarding any impairment in the space provided below.

	<u>YES</u>	<u>NO</u>	<u>DATE</u>		<u>YES</u>	<u>NO</u>	<u>DATE</u>
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)	<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"/>	_____	Goiter (Struma)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headache (Persistent)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Type _____ Is the student a carrier? _____				Vertigo, Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parasites	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	_____

- Has the student experienced disease, impairment or abnormality of any of the following?

Abdominal Organs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genito-Urinary System	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones, Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart or Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood, Endocrine Sys.	<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"/>	_____

- Additional Comments, if yes to above: _____

- Does student have any allergies? Yes No If yes, please describe. _____

- Can allergies be controlled with medication? Yes No

- Is student currently using any prescription drugs and/or medication? Yes No If yes, give details and list specific drugs being used. _____

MEDICAL RELEASE AUTHORIZATION: I, the undersigned, certify that all important medical information has been included and that the above information is correct. I also authorize the host parents and the Community Representative, without liability or expense to themselves, to take whatever action they deem appropriate with regard to my son's or daughter's health and safety. They may place my son or daughter in a hospital for medical services and treatment or, if no hospital is readily available, may place them in the hands of a local medical doctor for treatment. I also authorize any physician to release any information acquired in the course of examination or treatment. I certify that the above information is correct to the best of my knowledge. This authorization shall be valid for the entire duration of the exchange program.

Parent/Guardian Name & Signature: _____ Date: _____

Emergency Contact Telephone Number: _____ Fax Number: _____