SHERWOOD SCHOOLS

A GREAT PLACE FOR ALL KIDS

June 8, 2016

To: OSAA Committee

Re: Alex Kullin

I'm writing this letter on behalf of one of our exchange students for the 2016/17 school year, Alex Kullin, from Sweden. He has been accepted to spend the year here in Sherwood, Oregon; residing with Jennifer Livingston and family, and attending Sherwood High School. He was not recruited to play any OSAA sports but looks forward to the opportunity to immerse himself in our culture, and participate in as many school activities as possible.

Sincerely,

Yvonne van Andel

Yvonne van Andel, MS
Sherwood HS Counselor,
Counseling Department Coordinator,
Foreign Exchange Coordinator

June 9, 2016

To Whom It May Concern:

We will be hosting an exchange student from Sweden, Axel Kullin, for the academic year of 2016-17, and he will be attending Sherwood High School. He is considered a "direct placement" exchange student, making him ineligible to participate in OSAA activities. We wish to petition for an exception for our future student.

We actually do not know Axel or his parents. We will be meeting him for the first time come August. My husband and I are friends with Axel's uncle, Patrick Bartle - I went to high school with Pat and consider him a close family friend. He has lived in Sweden for the past several years, and this January reached out to us through Facebook, explaining how he was helping his sister-in-law find a family to host Axel during his exchange. He simply asked if we could recommend a family - and we recommended ourselves. It was an effort to find a family for Axel that involved at least a minimal level of connection - beyond an EF family that would choose Axel from a profile on a website. Axel's mother, Sarah, has expressed what a relief it was to find a host family who a member of her family knows - making a stressful situation a little less so.

Axel has not has the opportunity to participate in many sporting activities, beyond track and field with a club in Sweden. He wishes to have an "All-American" experience and try to play American sports, no matter what level of team. As his future host parents, we are concerned that if he is not allowed to participate in sports, or other organized activities, at Sherwood, this may affect his ability to be involved in the high school in a genuine manner, not to mention making it more difficult to find a positive group of friends to support him during his exchange.

We hope you consider giving Axel an OSAA waiver. If you have any other questions or concerns, please contact us at any time.

Sincerely,

Don and Jennifer Livingston
23815 SW Middleton Road
Sherwood, Oregon 97140
(503) 625-0829
djlivingston3@yahoo.com

Oregon School Activities Association
25200 SW Parkway Avenue, Suite 1, Wilsonville, OR 97070
503.682.6722 FAX 503.682.0960 http://www.osaa.org

Foreign Student Eligibility Checklist

Definition: A "foreign student" is a student whose Joint Residence with his/her parents is located outside of United States.

In general, unless a foreign student is eligible as an incoming ninth grader or is eligible based upon Rule 8.6.3.(c) "Foreign Students on CSIET Approved Programs", the foreign student is ineligible to represent a member school for one calendar year.

Any hardship Eligibility Request Form submitted on behalf of a foreign student shall be submitted directly to the Executive Director. (Rule 8.6.8)

A foreign student is eligible to represent an OSAA member school when first enrolling in the school ONLY if:

- The foreign student first enrolls as an entering ninth grade student, OR
- The foreign student is attending school as a representative of a CSIET approved program AND the answer to each of the following questions is, "Yes."

Yes	No	N/A	
☑	☐	☐	Is the foreign student attending school in the attendance boundary where the host family resides?
☑	☐	☐	Does the foreign student's age satisfy OSAA age restrictions?
☑	☐	☐	Has the foreign student completed eleven or fewer years of education (excluding kindergarten)?
☑	☐	☐	Is this the first time that the foreign student has attended high school in the United States?
☑	☐	☐	Is it an accurate statement that no person affiliated with the school had any input in the placement of the foreign student at the school?
☑	☐	☐	***The host family is not a member (paid or voluntary) of the school's athletic department nor the coach/director of a non-athletic activity.***
☐	☑	☐	Is it an accurate statement that the foreign student was not a "direct placement" at the school? (Under OSAA Rules, a student is considered to be a "direct placement" if "...the student was placed in a specific high school and/or with a specific host family as a result of a request from the student or the student's family.")
☑	☐	☐	Is it an accurate statement that the foreign student has not been terminated from the CSIET program?

If the answer to any of the above questions is, "No," the foreign student is ineligible to represent a member school for one calendar year.

SHERWOOD SCHOOLS

A GREAT PLACE FOR ALL KIDS

Authorization to Release Records

Last School Attended: DANDERYDS GYMNASIUM, DANDERYD, SWEDEN

School Mailing Address: RINKEBYVAGEN 4, 18236 DANDERYD, SWEDEN

School Phone: +46 8 568 913 01 School Fax: +46 8 568 913 19

Student's Full Legal Name: CLAES AXEL BERTIL KULLIN

Birth date: MARCH 10, 1999 Grade/Graduation Year: 11th GRADE Start Date: AUG 2015

PLEASE IMMEDIATELY FAX transcript, withdrawal grades, immunizations, test scores, IEP/504 (current and eligibility), ELL (Woodcock Munoz scores) and birth certificate upon receipt of this request to facilitate enrollment and scheduling of the student.

Please **mail** the following records to the school indicated below:

- Official Transcript of Grades / Withdrawal Grades
- Cumulative Folder / Permanent Records
- Health Card / Immunization Record / Birth Certificate / Physical Exam
- ELL / TAG / 504 / IEP Records
- Behavioral Records
- All Testing Records / Scores

I hereby authorize the release of records and information as indicated for the above named student. I have been notified of my right to receive a copy of the records, to review the records and to have a hearing to remove or correct any information that is inaccurate, misleading or otherwise violated the student's right to privacy, or other rights.

[signature] JUNE 29, 2016

Parent/Legal Guardian or Registrar Date

PLEASE SEND RECORDS TO:

____ **Archer Glen Elementary**
16155 SW Sunset Blvd.
Sherwood, OR 97140
Office: (503) 825-5100
Fax: (503) 825-5101

____ **Edy Ridge Elementary**
21472 SW Copper Terr.
Sherwood, OR 97140
Office: (503) 825-5700
Fax: (503) 825-5701

____ **Hopkins Elementary**
21920 SW Sherwood Blvd.
Sherwood, OR 97140
Office: (503) 825-5200
Fax: (503) 825-5201

____ **Middleton Elementary**
23505 SW Old Hwy 99
Sherwood, OR 97140
Office: (503) 825-5300
Fax: (503) 825-5301

____ **Laurel Ridge Middle School**
21416 SW Copper Terr.
Sherwood, OR 97140
Office: (503) 825-5800
Fax: (503) 825-5801

____ **Sherwood Middle School**
21970 SW Sherwood Blvd.
Sherwood, OR 97140
Office: (503) 825-5400
Fax: (503) 825-5401

__X__ **Sherwood High School**
16956 SW Meinecke Rd.
Sherwood, OR 97140
Office: (503) 825-5500
Fax: (503) 825-5520

EF EducationFirst

High School Exchange Year

Student number S E 5 7 3 4 3 7 4

Name Kullin (Last name) Axel (First name)

Certificate of Health

IMPORTANT: TO THE EXAMINING PHYSICIAN

Both sides of this form must be filled out in their entirety. Please do not leave any blank spaces. The doctor completing this form must be familiar with the student's entire medical/mental health history, and should consult fully with the natural parents/guardian of the student to ensure that the form is as complete and accurate as possible.

1. Date of birth (m/d/y) 03/10/99 Height 183 Weight 73 Gender M Blood group: _____
   Blood Pressure: _____ Sys 120 Dia 75 Pulse rate 60 Regular Reg.
2. Are reflexes normal? ☑ Yes ☐ No _____ Pupil norm. Knee norm. Other norm.
3. Is vision normal? ☑ Yes ☐ No ☐ Student uses glasses ☐ Student uses lenses
4. Is there evidence of any other disease, impairment, or abnormality? _____
5. Excluding treatment for routine illness (influenza etc), describe in detail any medication taken or treatment received by the student currently or as noted in his/her past medical history (including hospitalizations). Please provide dates and details for each incident. _____
6. Does the applicant have any health limitations or any pertinent medical information that is important for EF High School Exchange Year to know should the applicant be considered for placement abroad? _____
7. Will the student be required or encouraged to seek any type of medical attention, treatment or check-ups during the exchange year? ☐ Yes ☑ No
   If yes, please explain: _____
8. Does this student have a medically diagnosed allergy (pets, food, environment, etc.)? ☐ Yes ☑ No
   If yes, what treatment is required: _____
   If the student has a pet allergy, would it be medically recommended that they live in a home without pets? ☐ Yes ☑ No
9. Will the student be required or encouraged to take any type of prescription or non-prescription drugs, vitamins or supplements during the exchange year?
   ☐ Yes ☑ No If yes, please explain: _____
10. Has the applicant ever suffered from any of the following physical or medical conditions? Indicate by checking the box in the appropriate column for "Yes" or "No".

	Yes	No		Yes	No		Yes	No
Asthma	☐	☑	Serious or persistent cough	☐	☑	Genito-urinary system	☐	☑
Appendicitis	☐	☑	Serious persistent headache	☐	☑	Heart or blood vessels	☐	☑
Diabetes	☐	☑	Typhoid fever	☐	☑	Other abdominal organs	☐	☑
Epilepsy	☐	☑	Vertigo or dizziness	☐	☑	Skin (acne, etc.)	☐	☑
Hepatitis: if yes, what kind? _____	☐	☑	**Any disease, impairment or abnormality of:**			Lungs, respiratory system	☐	☑
Hernia	☐	☑	Eyes or sight	☐	☑	Bones, joints or locomotor system	☐	☑
Pneumonia	☐	☑	Ears or hearing	☐	☑	Brain or nervous system	☐	☑
Psoriasis	☐	☑	Tonsils, nose or throat	☐	☑	Blood or endocrine system	☐	☑
Rheumatic fever	☐	☑	Tonsils removed	☐	☑	Does patient now have any	☐	☑
Scarlet fever	☐	☑	Stomach or digestive system	☐	☑	communicable disease?		

11. If "yes" to any of the above, please give a detailed explanation. _____
12. Have any members of the applicant's family (grandparents, parents, brothers, sisters) ever suffered from any of the following:
    Diabetes ☐ Yes ☑ No Tuberculosis ☐ Yes ☑ No Mental or nervous disorder ☐ Yes ☑ No
    If yes, please give a detailed explanation _____

Student number | S | E | 5 | 7 | 3 | 4 | 3 | 7 | 4 |

13. Is the student currently or have they ever experienced any of the following?

Check box for each below:	Yes	No
Health condition or injury other than routine illness (flu etc)	☐	☑
Hospitalization for any reason	☐	☑
Allergy (pets, food, environmental substance) or allergic reaction	☐	☑
Physical disability	☐	☑
Learning disability or condition (ADD/ADHD, dyslexia etc)	☐	☑

If yes to any questions, please explain: _____

14. Has this student to your, their or their natural parent's knowledge, ever experienced any of the following: (check boxes)

	Yes	No		Yes	No
Eating disorder (anorexia, bulimia, etc.)	☐	☑	Constant worry, anxiety, high stress, depression or sadness	☐	☑
Significant weight loss or weight gain for any reason	☐	☑	Cutting or hurting yourself (or thoughts of doing this)	☐	☑
(including restricted eating, excessive exercise, purging, etc.)	☐	☑	Emotional, physical or sexual abuse	☐	☑
Thoughts of suicide	☐	☑	Bullying or other social/family adjustment issues	☐	☑

If yes to any questions, please explain: _____

Has this student ever talked to a professional or another trusted adult (teacher, counselor, doctor, therapist, pastor, etc.) about any of the above or other issues? (check box) ☐ Yes ☑ No If yes, please explain: _____

In my opinion, the general state of student's health is: ☑ Excellent ☐ Good ☐ Fair ☐ Poor

May the student participate in athletics? ☑ Yes ☐ No List restrictions, or mark "none": _____

Physician (name in print) Johannes Krilsa Telephone +46851258800

Signature of physician _____ Date of examination 03/31/2016

Address Skeppsbron 46

Postal code and City 11130 Stockholm Sweden

IMPORTANT!

THE EXAMINING PHYSICIAN CANNOT BE A PARENT OR RELATIVE OF THE STUDENT. EACH "CERTIFICATE OF HEALTH" WILL BE EXAMINED BY EF. ANY QUESTIONS CONCERNING THE INFORMATION CONTAINED HERE WILL BE FORWARDED DIRECTLY TO THE EXAMINING PHYSICIAN.

MEDICAL RELEASE

To be filled out by the parents or legal guardian: We certify that the records above are complete and accurate. We realize that any misstated or omitted information regarding our son/daughter's medical/psychological history may affect his or her acceptance to or continued participation on the exchange program. We also understand that our son/daughter must complete all inoculations/testing per the requirements stated on this certificate. Should there be any new developments in our child's medical or mental health after the submission of this form and prior to departure, we agree to inform EF High School Year immediately. Failure to comply with these requirements may also affect his or her acceptance to or continued participation on this exchange program.

We hereby give our full consent for our son/daughter to receive any medical/mental treatment or to undergo any emergency operation which is determined by a medical/mental health professional and may become necessary during his/her stay abroad. This includes shots or inoculations. Should the need arise for our child to be examined by a medical or mental health professional, these evaluations will not be confidential. We, the natural parents or guardian, authorize the direct disclosure of these evaluations and records to EF Foundation and/or its affiliates. Should the student be age 18 or over, his or her signature on this document also constitutes agreement to the direct disclosure of the said records. We also accept full responsibility for any medical expenses for our son/daughter which are not covered by his/her insurance policy.

Student's signature _____ City and date TABY 04/10/16

Mother's/legal guardian's signature _____ City and date TABY 04/10/16

Father's/legal guardian's signature _____ City and date TABY 04/10/16

This document contains confidential contact and health information. It should be shared only with the student's approved HF, IEC, RC, EF Foundation and school staff and any medical/mental health professionals involved in examining or monitoring the student.

1. KULLIN
2. CLAES AXEL BERTIL
3a. 990310-0171
7. 03 FEB/FEB 21
10. Axel Kullin

TELEPHONE NO. FOR CHECK OF VALIDITY
SWEDISH POLICE +46 77 114 14 00

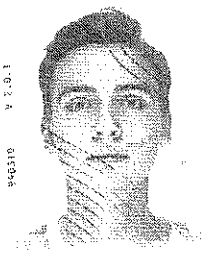
PASS
PASSPORT
PASSEPORT

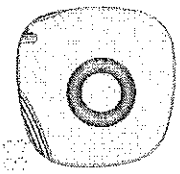
SVERIGE SWEDEN SUÈDE

Typ/Type P
Kod/Code SWE
Pass nr/Passport No. 90901780

1. Efternamn/Surname(s)
KULLIN
2. Förnamn/Given name(s)
CLAES AXEL BERTIL
3. Nationalitet/Nationality
SVENSK SWEDISH
4. Födelsedatum/Date of birth
10 MAR/MAR 99
5. Kön/Sex
M/M
6. Utfärdad/Date of issue
03 FEB/FEB 16
7. Sista giltighetsdag/Date of expiry
03 FEB/FEB 21
8. Födelseort/Place of birth
RÄSUNDA
9. Myndighet/Authority
POLISMYNDIGHETEN

3a. Personnr/Pers. id. no.
990310-0171
4a. Längd/Height
183 CM





10. Personnummer/Signature
Axel Kullin

P<SWEKULLIN<<CLAES<AXEL<BERTIL<<<<<<<<<<<<<<
90901780<8SWE9903104M2102034199903100171<<56

EF

High School Exchange Year

Student number S E 5 7 3 4 3 7 4

Name Kullin (Last name) Axel (First name)

Immunization Records

IMPORTANT: PLEASE COMPLETE ALL SECTIONS!
All student travelling to the USA are required to get all vaccines listed below prior to departure. Without these inoculations a student cannot register in a U.S. high school. It is important to write month, day and year. Each state and school has different inoculation requirements. If the student arrives without complete inoculations, the student's natural parents or legal guardians are responsible for any and all costs incurred and the student's continued program participation cannot be guaranteed.

REQUIRED IMMUNIZATIONS
ALL DOSES INDICATED BELOW ARE REQUIRED FOR SCHOOL ENTRY IN THE US

Please write Dates Received as Month/Day/Year

VACCINE	REQUIREMENT	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE
Diphtheria	5 doses (one of them after the student's 4th birthday)	05/01/2000	03/03/2000	01/10/2000	10/10/2009	04/06/2016
Tetanus		05/01/2000	03/03/2000	01/10/2000	10/10/2009	04/06/2016
Pertussis		05/01/2000	03/03/2000	01/10/2000		04/06/2016
Oral/Inactivated Polio	4 doses (at least 1 after the fourth birthday)	05/01/2000	03/03/2000	01/10/2000	10/03/2005	

If you have received the oral 3-dose Polio series and/or are not missing a dose of the inactivated poliovirus vaccine (IPV), please tick this box and write the dates above. ☐

VACCINE	REQUIREMENT	1ST DOSE	2ND DOSE	3RD DOSE	
Hepatitis B	3 doses (2 if the 2-dose series was given before the student was 16 months old)	02/01/2011	02/24/2011	09/27/2011	

If you have received the new 2-dose Hepatitis series, please tick this box and write the dates above ☐

		1ST DOSE	2ND DOSE		DATE OF DISEASE MM/DD/YY
Measles	not valid before 1st birthday	04/10/2001	10/10/2010	- or -	
Mumps		04/10/2001			
Rubella		04/10/2001	Text		
Chicken Pox	2 doses required unless disease is documented				10/2004

RECOMMENDED IMMUNIZATIONS
(SOME US STATES REQUIRE ONE OR BOTH OF THESE FOR SCHOOL ENTRY)

VACCINE	1ST DOSE	2ND DOSE
Hepatitis A	02/01/2011	02/24/2011
Meningococcal MCV4		
Other		

Has the student ever been diagnosed with tuberculosis (TB)? ☐ Yes ☑ No

The student must either show proof of a TB test or a BCG inoculation below in order to ensure that he/she is not infected with TB.

BCG Inoculation: ____________ (date of inoculation mm/dd/yy)

US School Nurse: Please note that students inoculated with a BCG vaccine may likely show a false positive result when given the TB skin test. If you need further information, please contact EF Foundation.
Student and Natural Parents: Please note that a US school may require secondary confirmation of the BCG inoculation or further testing to prove that the student is not infected with TB.

- or -

TB Test

(Should be administered within 1 year of expected US school start date or an additional test may be required for school enrollment upon arrival in the US)

Test Type: ☐ Skin Test ☐ Blood Test ☑ Chest X-ray TB Test Administered: 04/08/2016 (date of test mm/dd/yy)

Date of Test Results (skin test must be read 3 days after administration): ____________ (date of results mm/dd/yy)

Did the skin test indicate that the student may have TB? ☐ Yes ☐ No

If yes, a chest X-ray must be administered. Did the chest X-Ray indicate that the student has active or contagious TB? ☐ Yes ☑ No ☐ Not applicable

Signature of physician ____________ Date of examination 04/10/2016

This document contains confidential contact and health information. It should be shared only with the student's approved HF, IED, RC, EF Foundation and school staff and any medical/mental health professionals involved in examining or monitoring the student.

High School Exchange Year

Student number: 5 6 5 7 3 4 3 7 4

Name: Kullin (Last name) Axel (First name)

To the teacher or school staff: This student is applying for a High School Exchange Year with EF. We would appreciate your kind assistance in certifying the accuracy of the grades and hours per week stated below. Please type or print clearly, using a black ball-point pen.

Student's family name: Kullin First name: Axel Date of birth: 03 (Month) / 10 (Day) / 99 (Yr)

Record of last two years from below-mentioned school(s):

Previous sc: ___ Type of school ___ Grade/Class ___

Current sc: Skarpängsskolan — Type of school ___ Grade/Class ___

Street Add: Ljungmyrsvägen 20-24 — Postal code ___ City ___

Country: Sweden — Telephone (___) ___

187 46 Täby
08-55 55 83 01

Please note: Applicants are expected to have an equivalent to a "C" average in their potential exchange country in all major/academic classes during the most recent 2 semesters. Students must also have an equivalent overall "C" grade point average.

What is the grading scale? Highest grade possible: A Failing grade: F Lowest possible grade: E

Student's grade point average last year ___ This year ___ Years of host country language study ___

Does the student have any learning difficulties? ☐ Yes ☒ No If yes, does the student require extra help? ☐ Yes ☒ No

Is this a high school only for students with special needs? ☐ Yes ☒ No

If you answered "yes" to either of the above please explain: ___

Please fill in the last two years of schooling in your school's grading system (please do not translate grades to grades in potential exchange country):

Subjects/Grades (Please specify which languages are studied)	Class/Grade 8 — 2nd semester 20 13 — weeks in semester: 12 — Grades / Hrs per week	Class/Grade 8 — 1st semester 20 14 — weeks in semester: 21 — Grades / Hrs per week	Class/Grade 9 — 2nd semester 20 14 — weeks in semester: 12 — Grades / Hrs per week	Class/Grade 9 — 1st semester 20 15 — weeks in semester: 21 — Grades / Hrs per week
Native language: Svenska	E 12,33	D 12,83	D 12,83	C 12,83
Native language:	/	/	/	/
1st foreign language: English	C 11,83	B 11,83	A 12,0	A 12,0
2nd foreign language: Spanish	E 12,5	D 12,5	D 12,5	D 12,5
3rd foreign language:	/	/	/	/
History	D 10,75	D 10,75	D 10,75	D 10,75
Geography	D 10,75	C 10,75	C 10,75	C 10,75
Social Science	E 10,75	E 10,75	E 10,75	E 10,75
Religion	E 10,75	D 10,75	D 10,75	D 10,75
Philosophy	/	/	/	/
Mathematics	C 12,75	D 12,25	D 12,83	C 12,83
Physics	C 10,90	C 10,90	C 11,0	C 11,0
Chemistry	E 10,90	E 10,90	D 11,0	D 11,0
Biology	C 10,90	C 10,90	C 11,0	C 11,0
Physical Education/Gymnastics	D 11,83	C 11,83	B 11,83	A 11,83
Art	C 10,90	C 1090	C 11,0	A 11,0
Music	E 10,67	D 10,67	D 10,67	B 10,67
Other: Home Economics	E 10,33	E 10,83	D 10,33	D 10,33
Other: Crafts	C 11,34	C 11,34	C 10,34	B 11,34
Other: Technology	D 10,90	D 10,90	D 11,0	C 11,0
Total number of hours per week	23,5	23,5	24,16	24,16
Days of absence				

I hereby certify the accuracy of the information above:

Name (in print): Katarina Kihlberg

Signature: ___

Title: Skoladm, Skarpängsskolan

Date: ___

Ljungmyrsvägen 20-24
187 46 Täby, Sweden
+46-8-55 55 83 01
katarina.kihlberg@taby.se

Stamp of Current School (mandatory)

Note to EF co: ___ et information on this form if showing to a host family applicant.

oof Exchange Year
w.ef.com

Last updated: April 3, 2014