# DREW UNIVERSITY TRAVEL HEALTH FORM

Program Name and Location_____ Length of Program_____

Participant Name_____ Date of Birth_____ M____F____
Permanent Address_____Phone_____

*Emergency Contacts:*
Name_____ Daytime phone_____
Relationship _____ Evening phone_____

Name_____ Daytime phone_____
Relationship _____ Evening Phone_____

Candid reporting of your state of health and discussion as to whether the needs of any physical or psychological condition can be met while away from home is the best way to safeguard your well-being. Ultimately, you are responsible for your own health and safety while participating in your chosen program.

1) Do you have any medical condition that warrants regular medication or physician follow up? Y N
If yes, please explain:

2) Do you have a medical condition that is stable now, but could recur? Y N
If yes, please explain:

Please check if you currently have or have had any of the following:

__ Hepatitis
__ Chicken Pox
__ Mumps
__ Mononucleosis
__ Malaria
__ Tuberculosis
__ Rubeola (measles)
__ Rubella (German measles)
__ substance addiction/abuse
__ depression/anxiety/panic attack
__ eating disorder
__ head injury/loss of consciousness
__ convulsions/epilepsy/seizures
__ heart condition
__ blood problem/clotting disorder
__ eye problems
__ ear, nose, throat problems
__ stomach problems
__ kidney disease/injury
__ diarrhea/constipation
__ anemia
__ high/low blood pressure
__ currently pregnant
__ diabetes
__ arthritis
__ psoriasis
__ back problems
__ asthma
__ motion sickness
__ frequent insomnia

Allergies: _____ Reactions: _____

Current medications: _____

I certify that the information above is complete and correct to the best of my knowledge, and I have discussed any medical and/or psychological condition with my health care provider and program director. I understand that if my health changes between now and when the program begins, I must submit a written statement from a health care provider describing my current condition and the advisability of my participation in the program.

I agree to the release of this medical information to the program director and program staff. In the case of a potentially life threatening emergency or in the case of a risk of serious imminent harm to my health and safety or that of others, pertinent medical or counseling information may be shared with emergency care providers, appropriate emergency contacts, and other school officials as necessary. I authorize the program director to facilitate the provision of medical services, or when circumstances require immediate action, to proceed according to standard medical practice in my treatment.

Date_____ Participant's Signature_____

# DREW UNIVERSITY TRAVEL HEALTH FORM

Participant Name _____

Program Name and Location _____ Length of Program _____

## TO BE COMPLETED BY HEALTH CARE PROVIDER:

Please evaluate the physical and emotional health of this individual who plans to participate in a program abroad. Participation in an abroad program can be physically and mentally demanding and it is important that he/she be able to adjust to the demands of a new and different environment. It is essential that your evaluation be based on a current knowledge of this individual's medical history.

Please list the date(s) of the following vaccinations received by the student (do not attach separate sheet):

| | | | |
|---|---|---|---|
| MMR | _____ | Polio | _____ |
| Hepatitis A | _____ | Tetanus | _____ |
| Hepatitis B | _____ | Typhoid | _____ |
| Meningococcal | _____ | Yellow Fever | _____ |
| Flu | _____ | | |

If the answer to any of the following is "yes", please provide details in the space below:

1. Is the individual allergic to any drugs or medication? Y N
2. Does the individual have any speech, hearing or vision impairment that might affect participation? Y N
3. Does the individual have any condition that might be worsened due to change or strenuous travel? Y N
4. Has the individual ever suffered from asthma or any other respiratory ailment? Y N
5. Is the individual currently under treatment for a mental health concern? Y N
6. Does the individual take prescription medication? Y N
   If yes, please list below

Is there any other pertinent health information not covered by the questionnaire above that the program director or a qualified health care provider should be aware in the event of a medical emergency? If so, please explain.

I have discussed his/her health condition with this individual as it relates to the demands of international travel and believe that he/she is prepared to participate in the program.

Date_____ Signature of Health Care Provider_____

Office Stamp: