

**PACIFIC LUTHERAN UNIVERSITY OFF-CAMPUS CONFIDENTIAL MEDICAL STATEMENT FOR TRAVEL**  
**2012-2013**

Name (please print) \_\_\_\_\_ Destination \_\_\_\_\_ Program Dates \_\_\_\_\_

J-Term \_\_\_\_\_ Semester \_\_\_\_\_ PLU ID # \_\_\_\_\_ Cell Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

Permanent Mailing Address \_\_\_\_\_ Home Phone \_\_\_\_\_

College Mailing Address \_\_\_\_\_

Emergency Contact Address \_\_\_\_\_

1<sup>st</sup> Emergency Contact \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Name, Last Name Relationship Cell Phone/Email

2<sup>nd</sup> Emergency Contact \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Name, Last Name Relationship Cell Phone/Email

YES	NO		Description (additional space on back)
		Are you currently taking any medications? <i>If yes, please list.</i>	
		Do you have any allergies to medications, foods, etc.? <i>If yes, please list.</i>	
		Do you have any significant health care problems, i.e., diabetes, epilepsy, heart, asthma or depression? <i>If yes, please describe.</i>	
		Do you have any significant mental health problems, i.e., depression, anxiety, eating disorder? <i>If yes, please describe.</i>	
		Have you had any injuries or significant illnesses in the last five years? <i>If yes, please explain.</i>	
		Are you concerned about your alcohol or drug use? <i>If yes, please explain.</i>	
		Have you been treated for substance abuse? <i>If yes, please explain.</i>	
		Do you have any physical limitations and/or documented disabilities as defined by ADA? <i>If yes, please describe any special assistance you may need – notify the program leader as soon as possible.</i>	
		Have you been under the care of a therapist, psychologist, psychiatrist, or other mental health professional during the past four years? <i>If yes, please have this form signed by your counselor below.</i>	
		Is there any other medical information that you feel the program director should know about you? <i>If yes, please explain.</i>	

**Insurance Requirement**

All students are required to have personal health insurance and to carry an insurance card. Students are financially responsible for all personal medical expenses.

**Medical/Mental Health Release of Information**

I understand that my express consent is required to release any health care information. I request and authorize PLU Health Service to release health care information to the Department sponsoring my travel, the instructors and others as medically necessary. If I have been diagnosed or treated for HIV (AIDS virus), psychiatric disorders/mental health, or drug and/or alcohol use, PLU Health Service is specifically authorized to release all health care information relating to such diagnosis or treatment.

**Travel Immunization Information**

I am aware that certain locations require additional immunizations and that it is my responsibility to attend the pre-departure orientation at which health information will be provided by the PLU Health Service or the Department sponsoring the travel. If I am unable to attend, it is my responsibility to schedule an appointment to receive this information at the PLU Health Service.

**Consent for Medical Treatment**

The undersigned gives consent to PLU program representatives to authorize any necessary medical or surgical treatment in case of any medical emergency as confirmed by any attending physician involving the undersigned student while attending the PLU Off-Campus program. If the student is less than 18 years of age the PLU program representative shall attempt to contact the undersigned parent or guardian for approval before relying on this authorization. In addition, the undersigned student must personally consent to said medical procedure if said student is physically and emotionally capable at the time such treatment is required.

By my initials below I certify that I have read and understand the information on this form:

\_\_\_\_\_ INSURANCE REQUIREMENT                      \_\_\_\_\_ MEDICAL/MENTAL HEALTH RELEASE OF INFORMATION  
\_\_\_\_\_ TRAVEL IMMUNIZATION INFORMATION      \_\_\_\_\_ CONSENT FOR MEDICAL TREATMENT

\_\_\_\_\_ I understand if there are any changes in my health status during this academic year that it is my responsibility to notify the PLU Student Health Center.

**IN THE EVENT IT IS NECESSARY TO RELY ON THIS CONSENT TO AUTHORIZE NECESSARY MEDICAL CARE AND TREATMENT FOR SAID STUDENT, THE UNDERSIGNED, INDIVIDUALLY AND JOINTLY, AGREE TO INDEMNIFY AND HOLD THE PLU PROGRAM REPRESENTATIVE AND UNIVERSITY HARMLESS FROM THE COSTS INCURRED FOR SAID EMERGENCY CARE AND TREATMENT, INCLUDING REASONABLE ATTORNEY FEES AND COSTS INCURRED IN DEFENDING AND/OR INSTITUTING A SUIT TO RECOVER SAID MEDICAL EXPENSES.**

**FURTHERMORE, I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND COMPLETE.**

**Student Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian signature required if under 18 years of age.**

**Parent/Guarding Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

.....  
**Leave this section blank** and bring this form to your university's health center or your primary medical provider. Your medical provider should then return this form to the Wang Center for Global Education.

**Allergies:**

\_\_\_\_\_

*Based on my review of this student's medical history and physical examination findings, I have not identified any extraordinary health risks that would prohibit this student from studying abroad.*     YES     NO

*It is my professional opinion that this student is stable to study off campus.*

YES     NO     INSUFFICIENT INFORMATION

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Medical Provider)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Counselor - **if applicable**)

Print Name & Number: \_\_\_\_\_

Print Name & Number: \_\_\_\_\_

**Note to Health Center or medical provider: Please return this form to Pacific Lutheran University, Wang Center for Global Education, Tacoma, Washington, 98447; Fax: 253-535-8752; wangctr@plu.edu**

**Additional Space for Listing Responses on Reverse Side:**

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