

PACIFIC LUTHERAN UNIVERSITY OFF-CAMPUS CONFIDENTIAL TRAVEL MEDICAL STATEMENT 6/07

Name (please print) _____ Destination _____ Dates _____

JTerm _____ Sem. _____ School ID # _____ Birth Date _____

Example: 09/August/ 82

School Address _____ School Phone # _____

Person to Notify in Case of Emergency _____ Best Contact # _____

YES NO

_____ Are you currently taking any medications? If yes, list: _____

_____ Do you have any allergies to medications, foods, etc. If yes, list: _____

_____ Do you have any significant health care problems, i.e., diabetes, epilepsy, heart, asthma or depression? If yes, describe: _____

_____ Do you have any mental health issues, i.e., depression, anxiety, eating disorder? If yes, describe: _____

_____ Are you currently receiving any treatment (i.e. medication, counseling/therapy) for any of these issues? If yes, with whom? _____

_____ Have you had any injuries or significant illnesses in the last five years? If yes, explain: _____

_____ Are you or others concerned about your alcohol or drug use? If yes, explain: _____

_____ Have you been treated for substance abuse? If yes, explain: _____

_____ Do you have any physical limitations and/or documented disabilities as defined by ADA? If yes, describe any special assistance you may need: _____ *If yes, you must notify the instructor as soon as possible.*

_____ Is there any other medical information that you feel the program leader should know about you? If yes, explain: _____

HEALTH UPDATE AGREEMENT: I understand if there are any changes in my health status before and during my off-campus study that it is my responsibility to immediately notify the Health Center and my program leader.

INSURANCE REQUIREMENT

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

MEDICAL RELEASE OF INFORMATION

I understand that my express consent is required to release any health care information. I request and authorize my university’s Health Center and Counseling Office to release health care information to the PLU Wang Center, the instructor(s), and others as medically necessary. If I have been diagnosed or treated for HIV (AIDS virus), psychiatric/mental health issues, or drug and/or alcohol use, my university’s Health Center and Counseling offices are 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 health precautions and that it is my responsibility to attend the pre-departure orientation at which health information will be provided by the Health Center or department sponsoring the travel. In addition, it is my responsibility – if I am traveling to a place requiring immunizations or medications – to schedule an appointment to receive travel-related health information at the Health Center or with my own health care provider.

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 participating in PLU Off-Campus study. If the student is under 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.

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.

By my initials below I certify that I have read and understand the above:

- _____ INSURANCE REQUIREMENT
- _____ MEDICAL/MENTAL HEALTH RELEASE OF INFORMATION
- _____ TRAVEL IMMUNIZATION INFORMATION
- _____ CONSENT FOR MEDICAL TREATMENT

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

← Student Signature: _____ Date: _____

Parent or Guardian signature required if under 18 years of age: _____ Date: _____

For Off-Campus Study – PLU students leave this section blank and submit to the Wang Center for International Programs or sponsoring department. The form will then be forwarded to the Health Center and Counseling & Testing for completion. Students from other universities who are participating in PLU programs should forward this form to their campus Health Center and Counseling Office for completion.

Allergies: _____

This is to certify that there is no known reason that would prevent this student per his/her medical history from successful participation in the above named program.

Signature: _____ Date: _____ Signature: _____ Date: _____

(Physician, Nurse Practitioner or Physician Assistant)

(Counselor – if applicable)