Health Form for Independent International Travel: 2018-2019 Departures

An important resource for planning successful international travel, submitting a Health Form is required for participation in any Independent International Travel. Have this signed by the PLU Health Center or personal provider.

Name _____ **PLU ID** _____ **Program Dates** (approx.) m m y y - m m y y

Destination(s)_____ **Birth Date**_____ **Cell**_____

Check all that apply: **J-Term** ☐ **Summer** ☐ **Semester** ☐ **Full Year** ☐ **Spring Break** ☐ **Other** ☐ _____

1st Emergency Contact _____ / _____ / _____
First Name, Last Name — Relationship — Cell Phone/Email

2nd Emergency Contact _____ / _____ / _____
First Name, Last Name — Relationship — Cell Phone/Email

International Travel can be an enriching experience as well as a physically and mentally challenging one. Mild or pre-existing health conditions can become serious for some participants as they transition into an unfamiliar culture and environment. For this reason, we encourage all participants to fully disclose their health history so that we can prepare them properly for their experience, make arrangements for any accommodations if necessary, and in some cases, assess whether there may be any health reasons that an applicant should consider another program.

Yes	No		Description (attach additional sheet as needed)
		Are you currently taking any medications? *If yes, please list.*	
		Do you have any allergies to medications, foods, etc.? *If yes, please list.*	
		Do you have any chronic health conditions, i.e., diabetes, epilepsy, heart disease, asthma, etc.? *If yes, please describe.*	
		Do you have any chronic mental health conditions, i.e., depression, anxiety, eating disorder, etc.? *If yes, please describe.*	
		Have you had any injuries or significant illnesses in the last five years? *If yes, please explain.*	
		Do you have any physical limitations and/or disabilities as defined by ADA? *If yes, please describe any accommodation you may need – notify the program leader as soon as possible.*	
		Have you been under the care of a therapist, psychologist, psychiatrist, or other mental health professional recently? **ACTION →** ***If yes, have this form signed by your mental health professional on 2nd page.***	
		Is there any other medical information that you feel the program leader should know about you? *If yes, please explain.*	

Travel Immunization Information
I am aware that certain locations require additional immunizations and that it is my responsibility to seek this information at the PLU Health Center or another healthcare provider qualified in travel medicine. I assume liability for not taking recommended medications or immunizations.

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
Student Medical Records are not included in the PLU Student Academic Record and all medical information shared with the PLU Health Center and PLU Counseling Center is confidential and protected by federal and state privacy regulations. I understand that my express consent is required to release any health care information. I request and authorize PLU Health Center and PLU Counseling Center to release medical or mental 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 Center and PLU Counseling Center are specifically authorized to release all health care information relating to such diagnosis or treatment. This release is in effect from the date this document is signed through the date that travel relating to the program is completed.

Consent for Medical Treatment
The undersigned gives consent to PLU 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 on Independent International Travel. 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.

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

_____TRAVEL IMMUNIZATION INFORMATION _____MEDICAL/MENTAL HEALTH RELEASE OF INFORMATION

_____INSURANCE REQUIREMENT _____CONSENT FOR MEDICAL TREATMENT

_____ I understand if there are any changes in my health status after this form has been signed by my provider that it is my responsibility to notify PLU.

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/Guardian Signature: _____ **Date:** _____

FOR PROVIDER USE ONLY *(Once complete, return this form to the PLU Finance and Administration Office)*

HEALTHCARE PROVIDER

☐ **SUPPORT: Based on my medical assessment of this student, I have not identified any extraordinary health risks that would prohibit this student from Independent International Travel.**

☐ ***FOLLOW-UP REQUIRED: Based on my medical assessment of this student, this student requires further medical/mental (circle) evaluation prior to Independent International Travel.**

Signature _____ Date _____
(Healthcare provider: DO, MD, NP, PA)

Print Name & Contact Info:

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NOTE TO MEDICAL PROVIDERS
Please return this form to:
Pacific Lutheran University, Admin. Services
Tacoma, Washington 98447
Fax: 253-536-5047 - lidensj@plu.edu

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*SECOND HEALTHCARE PROVIDER
(when further medical evaluation required)

☐ **SUPPORT: Based on my medical assessment of this student, I have not identified any extraordinary health risks that would prohibit this student from Independent International Travel.**

☐ **DO NOT SUPPORT: Based on my medical assessment of this student, I have identified extraordinary health risks that would prohibit this student from Independent International Travel.**

Signature _____ Date _____
(Healthcare provider: DO, MD, NP, PA)

Print Name & Contact Info:

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*MENTAL HEALTHCARE PROVIDER *(when applicable)*

It is my professional opinion that this student is stable to travel independently internationally.

☐ **Yes -or-** ☐ **Yes, with comment** *(i.e., drafted wellness plan, will stay on medication during program, needs ongoing care on-site, etc.)*

☐ **No**

Signature _____ Date _____
(Mental Healthcare Provider, when applicable)

Print Name & Contact Info:

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Comments:_____

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