PACIFIC LUTHERAN UNIVERSITY

Faculty/Staff Confidential Medical Statement for Travel: 2015-2016 Departures

Name ____ **PLU ID** ____________________ **Program Dates** ___________
(mm/yy-mm/yy)

Destination______________________________________ **Birth Date**______________ **Cell#**________________________

J-Term ☐ **Summer** ☐ **Semester** ☐ **Full Year** ☐ **Spring Break** ☐ **Other** ☐ ____________________________

1st Emergency Contact ____________________________________/_____________/___________________________
First Name, Last Name / Relationship / Cell Phone/Email

1st Emergency Contact Address ____

2nd Emergency Contact ____________________________________/_____________/___________________________
First Name, Last Name / Relationship / Cell Phone/Email

Yes	No		Description (additional space on back)
		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 significant health care problems, i.e., diabetes, epilepsy, heart disease, asthma, etc. *If yes, please describe.*	
		Do you have any significant mental health problems, i.e., depression, anxiety, eating disorder? *If yes, please describe.*	
		Have you had any injuries or significant illnesses in the last five years? *If yes, please explain.*	
		Are you concerned about your alcohol or drug use? *If yes, please explain:*	
		Have you been treated for substance abuse? *If yes, please explain.*	
		Do you have any physical limitations and/or documented disabilities as defined by ADA? *If yes, please describe any special assistance 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 during the past two years? *If yes, please have this form signed by your counselor below.*	
		Is there any other medical information that you feel the program director 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.

Insurance Requirement
All faculty/staff are required to have personal health insurance and to carry an insurance card. Faculty/staff 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 the release of my health care information as medically necessary.

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 faculty/staff member while attending the PLU Off-Campus program. In addition, the undersigned faculty/staff must personally consent to said medical procedure if said individual 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

In the event it is necessary to rely on this consent to authorize necessary medical care and treatment for said faculty/staff, 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.

Signature: ____ **Date:** ________________________