PACIFIC LUTHERAN UNIVERSITY

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 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 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 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 Center is specifically authorized to release all health care information relating to such diagnosis or treatment.

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 Study Away 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:

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

Leave this section blank and bring this form to the PLU Health Center or your off-campus healthcare provider. Your healthcare provider should then return this form to the Wang Center.

Allergies:_____

_____

Healthcare Provider

☐ ***Based on my medical assessment of this student, I have <u>not</u> identified any extraordinary health risks that would prohibit this student from studying away (international or domestic program off campus).***

☐ ***This student requires further medical/mental (circle) evaluation prior to study away (international or domestic program off campus).****

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

Print Name & Number:_____

_____

Mental Healthcare Provider** ***(when applicable)

It is my professional opinion that this student is stable to study away (international or domestic program off campus).

☐ **Yes** ☐ **No** ☐ **Insufficient Information**

Signature _____Date _____
(Mental Healthcare Provider, when applicable)

Print Name & Number:_____

Second Healthcare Provider** ***(when further medical evaluation required)

☐ ***SUPPORT: Based on my medical assessment of this student, I have <u>not</u> identified any extraordinary health risks that would prohibit this student from studying away (international or domestic program off campus).***

☐ ***DO NOT SUPPORT: Based on my medical assessment of this student, I have identified extraordinary health risks that would prohibit this student from studying away (international or domestic program off campus).***

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

Print Name & Number:_____

_____

Note to medical providers

Please return this form to:

Pacific Lutheran University, Wang Center
Tacoma, Washington 98447
Fax: 253-535-8752 - wang.center@plu.edu

T*he PLU Health Center will forward all completed medical forms to the PLU Wang Center for Global Education.*

Comments (attach additional sheets as necessary):

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