HEALTH FORM FOR INDEPENDENT INTERNATIONAL TRAVEL

(Print) Student Last Name: _____First_____Middle_____

PLU I.D. # _____ Date of Birth: Month_____ Day_____ Year_____

Purpose of travel: _____ Dates of travel: _____ to _____

Location (city/country): _____

Insurance Requirement - I understand that all students are required to have personal health insurance and to carry an insurance card. Students are financially responsible for all personal medical expenses.

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.

Consent for Medical Treatment - The undersigned gives consent to PLU to authorize any necessary medical or surgical treatment in case of any medical emergency as confirmed by any attending provider involving the undersigned student while participating in the Independent Travel. 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.

Student Signature:_____Date:_____

PERMISSION TO SHARE INFORMATION: I hereby give the Director of Risk Services (or a designee) and any representative of the university permission to communicate with one another and/or with my legal guardian, emergency contact person(s), medical professionals, regarding my independent travel experience, as necessary for university officials to perform their job duties. This may include but is not limited to the release of information from this health care form and my other educational records about my health and safety, student conduct or disciplinary matters, academic issues, student account information and/or any other relevant conduct or circumstance as it relates to my health and wellness before or during the study away program.

Student Signature:_____Date:_____

For Students Traveling with Medication

- *Contact the U.S. Embassy or Consulate to determine whether specific medications are legal in the country you are going to and that you can take a supply to last throughout your stay. Medications that are legal and commonly prescribed in the U.S. may be considered illegal, require a prescription, or a host country authorization to be allowed in the country.*
- *Carry a letter from your provider on letterhead, explaining your diagnosis, treatment, and list of prescribed medications. When going through Customs abroad, officials may scrutinize medications. Carry your prescription in original containers, and keep the letter from your provider handy.*
- *If you are taking an anti-depressant or other mental health medication, you must be stable on your medication. Medically stable means that you must be in a state where any changes in symptoms are not foreseen or expected. Discuss proper medication management with your provider **before** departure.*
- *If you are being treated for a psychological condition, work closely with your treating provider to design a treatment plan and understand possible triggers, what medications you are taking, if they are available overseas, and how to reach out for help while abroad, if needed.*
- ***Individuals cannot mail medications abroad.** Medications can only be mailed by registered practitioners or dispensers. Most countries have strict regulations on shipping medication abroad. Decisions on what medications are accepted into the country are made by the host country government; not the U.S. Post Office. Medications can be stopped by the host country's Customs that will require payment of fees, completion of documentation, and several trips to the Customs office.*

CERTIFICATION: I certify that:
I have personally completed this form. The information contained in this form is complete and I have not withheld any information about my physical or mental health. If any aspect of my health profile changes between submitting this form and my departure for an off-campus program, I will notify the Wang Center of these changes immediately, in writing. I understand that my failure to disclose any health information may jeopardize my ability to receive appropriate medical care in the event of an emergency while away. I further understand that, in the event of an emergency while away, the university reserves the right to notify my parent(s) or guardian.

Student Signature: _____ Date: _____

(Print) Student Name: _____

PROVIDER ASSESSMENT

TO BE COMPLETED BY A LICENSED MEDICAL OR MENTAL HEALTH PROVIDER WHO HAS SEEN THE STUDENT WITHIN THE PAST 6 MONTHS, OR MOST RECENT.

I am requesting that you complete this **PROVIDER ASSESSMENT** form in order to assess my potential needs in my independent travel program. I will share this information with Pacific Lutheran University and I give you permission to discuss my situation with the Director of Risk Services and other staff members of the university working to assess my ability to travel on a PLU sponsored trip.

Medical/Mental Health Release of Information

I understand that medical information is confidential and protected by federal and state privacy regulations, and I also understand that I may consent to the release of any and all of my health care information. I request and authorize my provider to release any and all medical or mental health care information to PLU as PLU may request. If I have been diagnosed or treated for HIV (AIDS virus), psychiatric disorders/mental health, or drug and/or alcohol use, my provider is 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.

Student Signature: _____ Date: _____

Note to the Provider: *Please complete and sign this assessment and return via fax or mail, as soon as possible, to*

Pacific Lutheran University
Director of Risk Services
12180 Park Avenue S.
Tacoma, WA 98447
Tel: 253-535-7116 | Fax: 253-535-8431

The above-named student has been elected to participate in an independent international travel program. Living and studying in a foreign environment often creates unexpected emotional and physical stress which can exacerbate otherwise mild conditions. It is important that all participants be able to adjust to dramatic changes in their living environment, climate, diet, and studying conditions that may disrupt their usual patterns of behavior. Your complete and candid evaluation of the student's physical and mental health is, therefore, extremely important to the student's success while traveling and to the university in working with the student to appropriately address any problems that might arise during the student's travel experience.

ASSESSMENT (TO BE COMPLETED BY PROVIDER)

if non, list "N/A". If none under your particular area of expertise, list "N/A under my expertise".

1. Diagnosis and description of student's health condition or disability:

   _____

   _____

2. Date of onset:_____

3. Prescribed medication and dosage:

   _____

4. If on medication, should the student continue on the medication throughout the time traveling?

   _____

5. What limitations are there, if any, on this student's participation in an extremely rigorous (emotionally and physically) program?

   _____

   _____

6. What accommodations are needed to assist the student in fully participating in the program?

   _____

   _____

7. What is the prescribed plan in the event that this condition becomes an acute emergency away?

   _____

   _____

8. **Based on the information provided by the student, and your personal review of the student's health history, and your recent travel consultation with the student, and their medical records on file in your office, please confirm, that, in your professional opinion:**

☐ There are no known contraindications to this student's participation in the program at this time.

☐ The student must obtain an additional assessment(s) from_____

_____

☐ There are medical or mental health contraindications to this student's participation in the program at this time (please describe the contraindications and how they impact the student's participation in the program; submit additional sheets if necessary): _____

_____

Licensed Provider's Signature: _____ **Date:** _____

(Print) Licensed Provider's Name: _____

Address & Phone or Office Stamp: _____