Health Form for Travel: 2017-2018 Departures [Faculty & Staff]

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

We encourage full disclosure of health history so that we can properly respond in the case of an emergency.

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.*	
		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 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 individual 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:

_____TRAVEL IMMUNIZATION INFORMATION _____MEDICAL/MENTAL HEALTH RELEASE OF INFORMATION

_____INSURANCE REQUIREMENT _____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:** ______________________