PLU WANG CENTER FOR GLOBAL AND COMMUNITY ENGAGED EDUCATION
PACIFIC LUTHERAN UNIVERSITY

Health Form for Travel: 2021-2022 Departures [Faculty & Staff]

We encourage full disclosure of health history so that we can properly respond in the case of an emergency. Please return the completed form to the Wang Center office or send via campus mail.

(Print) Last Name: _____ First_____ Middle Initial_____

Chosen or Preferred Name: _____

PLU I.D. # _____ Phone: _____ Date of Birth: _____

Sex Assigned at Birth: ☐M ☐F ☐Intersex Preferred Gender/Pronouns: _____

Study away program location(s):

_____

Term(s): ☐ Fall ☐ J-Term ☐ Spring ☐ Academic Year ☐ Spring Break ☐ Summer

Emergency Contact Name: _____Relationship:_____
Cell phone:_____Email:_____

Note: The information you provide is confidential. This form will be kept on file at the Wang Center and shared with on-site program staff and/or faculty/program leaders in the event of an emergency.

Yes	No		Description (attach additional sheet as needed)
		Are you currently taking/carrying any medications? (Please include inhalers and Epi-Pens.) *If yes, please list.*	
		Do you have any allergies to medications, foods, insects, latex, etc.? *If yes, please list.*	
		Do you have any chronic health conditions, i.e., diabetes, epilepsy, heart disease, asthma, etc.? *If yes, please list.*	
		Have you have been under the care of a medical specialist, counselor or other mental health professional in the last five (5) years?	

Insurance Requirement - I understand that 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.

Travel Immunization Information - I am aware that certain locations require additional immunizations and that it is my responsibility to seek this information from 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 program representatives to authorize any necessary medical or surgical treatment in case of any medical emergency as confirmed by any attending provider involving the undersigned individual while performing duties on the PLU Study Away program. In addition, the undersigned faculty/staff must personally consent to said medical procedure if said faculty/staff is physically and emotionally capable at the time such treatment is required.

Signature: _____ Date: _____

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 the release of any and all of my medical or mental health care information as medically necessary in PLU's sole discretion. This release is in effect from the date this document is signed through the date that travel relating to the program is completed.

Signature: _____Date: _____

Permission to Share Information - I hereby give the Executive Director of the Wang Center (or a designee) and any representative of the university permission to communicate with one another, study away program providers, and/or with my emergency contact person(s), medical professionals, regarding my study away 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.

Signature: _____ Date: _____

(Print) Last Name: _____ First_____ Middle Initial_____