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

2022-2023 Study Away Student Health Information Form

PART A - Student Self-Assessment

Student Name:____

Instructions: Please complete PRIOR to your appointment with your medical provider(s) and bring it with you. <u>This worksheet will NOT be submitted to the Wang Center</u> but is meant as a reflection tool and should be used as a starting point for discussion of important mental and physical health considerations when traveling. Being well prepared is the basis of having a rewarding and successful study away experience.

1. List any medications (including dosage) you are taking or may need to take during your program. Please include as needed medications, inhalers, and Epi-Pens. How do you plan to make sure that you can continue taking this medication during your program? Please consider that your medication should not be sent through the mail and that some medications may not be available and/or legal in some countries. ▢ Does Not Apply

   ____
   ____
   ____
   ____

2. Do you have any allergies to medications, food, substances, or insects? How do you plan to manage an allergic reaction should it occur? ▢ Does Not Apply

   ____
   ____
   ____
   ____

3. Do you have any special dietary restrictions or preferences? How do you plan to manage this while studying away? ▢ Does Not Apply

   ____
   ____
   ____
   ____

4. Do you have any acute or chronic medical conditions? How do you plan to manage while traveling? ▢ Does Not Apply

   ____
   ____
   ____
   ____

5. Do you have any mental, psychological or emotional conditions that have required treatment during the past 2 years? Do you have or have you had a history of an eating or substance abuse disorder? How do you plan to cope while traveling? If you have a counselor or therapist, have you discussed your study away plans with them yet?
   ▢ Does Not Apply

   ____
   ____
   ____
   ____

6. Stress during study away can exacerbate chronic medical and psychological conditions. How do you plan to cope while studying away so that you have an enjoyable and successful experience? If you are struggling, who can you ask for help and what other coping strategies do you have? ▢ Does Not Apply

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   ____
   ____
   ____

7. If you have any limitations of your mobility or ability to carry luggage how do you plan to manage? Are there plans in place if you are unable to participate in some activities such as hiking or field studies? ▢ Does Not Apply

   ____
   ____
   ____
   ____

8. What will you do if you experience a medical or psychological emergency while studying away? ▢ Does Not Apply

   ____
   ____
   ____
   ____

9. Have you traveled outside of the US before? If so, did you experience any mental or physical health challenges? ▢ Does Not Apply

   ____
   ____
   ____
   ____

Thank you for completing this self-assessment. Please bring your completed self-assessment (pgs. 1-2) to your appointment with your medical provider(s).

PART B - Student Health History

All students must submit a Student Health History form (Part B), regardless of whether they have a medical condition, in order to participate in a study away program. An additional Medical Specialty Provider Consultation (Part C) may be requested. The purpose of the Student Health History form (Part B) is to document your health history and any special needs you may have during the study away program. Your responses to the questions and prompts below will not change your acceptance into the study away program, and all information you provide will be treated CONFIDENTIALLY. The Student Health History form and additional Medical Specialty Provider Consultation form (as applicable) will be kept on file at the Wang Center and shared with on-site program staff and/or faculty/program leaders so they can serve you promptly and effectively in the case of an emergency.

Failure to submit the Student Health History form and any additional Medical Specialty Provider Consultations (as applicable), by the deadlines listed below may result in your removal from the program.

- May 15th Summer, Fall or Full-Year programs
- November 1st for J-Term and Spring programs
- March 1st for Spring Break programs

Students must inform the Wang Center for Global and Community Engaged Education of any recent (in the past 12 months) medical or special needs or changes in health that occur before the program start date.

(Print) Student Last Name: ____________________ First__________________ Middle______

Chosen or Preferred Name: ____

PLU I.D. # _______________ Phone: ___________________ Date of Birth: ______________

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

Name/location of all study away program(s):

____

____

____

Have you applied/are you intending to apply for another study away program in the same academic year? ☐ YES ☐ NO If YES, only one health form is required for the academic year.

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

Note: The questions below are similar to the prompts in Part A. This form is the version that will be kept on file at the Wang Center and shared with on-site program staff and/or faculty/program leaders as necessary.

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.*	
If you have been under the care of a medical specialist, counselor or other mental health professional, Part C may be necessary. Please discuss and request the form if needed.			

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 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 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.

Student Signature: ____ Date: ________________

If student is under 18yo
Parent/Guardian 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 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: ________________

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 legal guardian, 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 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 or up to six months after the study away program has ended.

→ Student Signature: ____ Date: ________________

CERTIFICATION: I certify that I have personally completed this form and that I have shared the Student Self-Assessment (Part A) with my healthcare provider(s). 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 Last Name: ____________________ First__________________ Middle______

FOR PROVIDER USE ONLY

Request Part A - Student Self-Assessment for review. Please complete and sign this form and return via fax or mail, as soon as possible, to

Wang Center for Global and Community Engaged Education | Pacific Lutheran University
12180 Park Avenue S.
Tacoma, WA 98447
Tel: 253-535-7577 | Fax: 253-535-8752

Student Name (print)____

Based on the information provided by the student, including their Student Self-Assessment (Part A), personal review of the student's health history, and review of available medical records, please confirm in your professional opinion (check one):

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and no further action is recommended.

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommended follow-up with a Specialty Provider. Please return Part C to the provider office listed at the bottom of this page.

____

____

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommend an additional Specialty Provider Consultation and that the student completes a written Self-Care Plan (see Part D for template) prior to this appointment and it is shared with the following parties in advance of departure:

____

____

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommend the student consult with the Wang Center in advance of departure to determine if reasonable accommodations are available.

____

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☐ 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). I recommend the student consult with the Wang Center to determine if there are accommodations or an alternate program that will accommodate the student's needs.:

____

____

Licensed Provider's Signature: _____________________________________Date: ____________

(Print) Licensed Provider's Name: ____

Office Stamp (with address and phone):

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PACIFIC LUTHERAN UNIVERSITY

PART C - Specialty Provider Consultation (only if required)

(Print) Student Last Name: ____________________ First__________________ Middle______

Chosen or Preferred Name: ____

Name/location of study away program(s):
(Please list all locations/dates if participating in consecutive programs)

____

____

Travel dates: ______________________

I am requesting that you complete this Medical Specialty Provider Consultation form in order to review my potential needs for study away. I will share this information with Pacific Lutheran University and I give you permission to discuss my situation with the Wang Center for Global and Community Engaged Education and other staff members of the university working to review my potential needs for study away.

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: _________________

PART II: To be completed by provider.

Request Part A - Student Self-Assessment for review. Please complete and sign this form and return via fax or mail, as soon as possible, to

Wang Center for Global and Community Engaged Education | Pacific Lutheran University
12180 Park Avenue S.
Tacoma, WA 98447
Tel: 253-535-7577 | Fax: 253-535-8752

Thank you for taking the time to meet with this student and complete this form. The student has received a travel health consultation for their intended study away program and they are being referred for an additional consultation prior to travel. Living and studying in an unfamiliar environment can trigger physical and emotional stress and exacerbate current health issues. Familiar or reliable healthcare or medications might not be readily available to the student in their host country.

Student Name (print)____

You are asked to:

- Discuss the student's healthcare needs with them in light of how it may affect their study away experience.
- If applicable, discuss prescription availability and medication plan with student.
- If applicable, collaborate with the student to complete a written Self-Care Plan and identify with whom the student may need to share their plan. Please indicate "N/A" as necessary.

Check one: ☐ PLU Counseling Center ☐ Non-PLU mental health provider
☐ Non-PLU medical provider

Based on the information provided by the student, including their Student Self-Assessment (Part A), personal review of the student's health history, and review of available medical records, please confirm in your professional opinion (check one):

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and no further action is recommended.

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommend the student shares their written Self-Care Plan with the following parties in advance of departure:

____

____

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommend the student consult with the Wang Center in advance of departure to determine if reasonable accommodations are available.

____

____

☐ 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 this program; submit additional sheets if necessary). I recommend the student consult with the Wang Center to determine if there are accommodations or an alternate program that will accommodate the student's needs.

____

____

Licensed Provider's Signature: ______________________________ Date: _________________

(Print) Licensed Provider's Name: ____

Office Stamp (with address and phone):

PART D - Self-Care Plan

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 Pacific Lutheran University's (PLU's) Wang Center, Health Center, Counseling Center, and/or Office of Accessibility and Accommodation 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: ________________

Given the health issue(s) that I have discussed with my health provider, here are some of the **challenges** that might arise within the context of my chosen study away program:

1. ____
2. ____
3. ____

Given the potential challenges, I have worked with my health provider to create a study away care plan that includes prevention, reasonable identification of warning signs and coping plans if in various levels of distress.

Routines/Prevention: Here are important steps to take on an ongoing basis to help best set myself up for success. Consistent use of the following behaviors will contribute to my success in this program.

Body (May include medications, sleep and eating routines, exercise, etc.):

Relationships (Including whom I will stay connected with regularly and how):

Centering Practices/Hobbies:

Reflection (How will I build in space for processing, mindfulness, or sense of purpose):

Reminders to myself that will be important:

Additional preventative steps I can take now:

<u>Triggers/Warning Signs/Signs of Distress</u> (situations, behaviors, thoughts, images, mood or body sensations that a concerning situation might be developing)

1. ____
2. ____
3. ____

<u>Coping Responses to Distress</u>:

What might distress look like for me?

What will I do on my own to cope with my distress?

Whom will I reach out to? How?

What are the most helpful behaviors for me if I am in mild to moderate distress? For program leaders or other staff on the program?

<u>Urgent Situation</u>:

What urgent situations might arise and what might distress look like?

What will I do on my own to cope if an urgent situation develops?

Whom will I reach out to? (<u>What is available</u>):

What are the most helpful behaviors from me/program staff in an urgent situation?

What are the realistic options for care in my location and in the event of an urgent situation?

What are the likely programmatic and family responses?

Here is what else is <u>important for program leaders/host family/fellow travelers/my parents or family to know</u>:

I have thoughtfully reviewed with my health provider potential challenges that may arise in my study away program. I understand that some challenges may interfere with my ability to fully participate in this study away program. I have reviewed the resources and tools I may need to fully participate in this program and have discussed the implications of this with my health provider.

Student Name (Print): ______________________Signature: ______________________ Date: ___________

Provider Name (Print): ______________________Signature: ______________________ Date: ___________