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

## 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.

_____

_____

☐ 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):