OFFICE OF STUDIES ABROAD
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www.up.edu/studyabroad

University of Portland

INTERNATIONAL TRAVEL HEALTH EVALUATION FORM

STUDENTS READ THIS FIRST: *Participation in a University of Portland study abroad program is contingent upon review of a student's completed "International Travel Health Evaluation Form." Read this form closely and complete it fully and accurately. Students should complete the first two pages first. Then, students should share the first two pages of the form with a licensed health care provider who will review the student's responses and complete the third and fourth pages after conducting a physical evaluation of the student. The form should then be returned to the Office of Studies Abroad at the University of Portland at the address listed on page four.*

STUDENT INFORMATION (To be completed by student):

Name Student ID: Date of birth

Study Abroad Program

MEDICAL HISTORY/CURRENT MEDICAL CONDITIONS (To be completed by student):

Do you currently experience or have you been treated in the past for the following conditions. Please circle YES or No and provide more details on back of form if you circle Yes.

YES or NO Allergies to medication
YES or NO Allergies of any kind
YES or NO Anaphylactic Shock
YES or NO Asthma
YES or NO Cancer or tumors
YES or NO Chronic respiratory problems
YES or NO Chronic digestive/GI problems
YES or NO Diabetes
YES or NO Dietary restrictions
YES or NO Dizziness/fainting spells
YES or NO Eating disorder
YES or NO Epilepsy or seizures
YES or NO Gastrointestinal trouble
YES or NO Head aches/migraine
YES or NO Head injury
YES or NO Heart or circulatory conditions
YES or NO High blood pressure
YES or NO Hypoglycemia
YES or NO Infectious disease
YES or NO Jaundice/hepatitis
YES or NO Kidney/urology problems
YES or NO Liver or gall bladder problems
YES or NO Menstrual problems
YES or NO Narcotic/alcohol dependency
YES or NO Psychological/emotional/psychiatric condition
YES or NO Neurological condition
YES or NO Orthopedic injury or condition
YES or NO Recent weight gain
YES or NO Recent weight loss
YES or NO Skin or ACNE condition
YES or NO Sleeping difficulty
YES or NO Thyroid/endocrine problems
YES or NO Trouble with ear, nose or throat
YES or NO Tuberculosis
YES or NO Sexually transmitted infection
YES or NO Vision correction
YES or NO Other
YES or NO Other

STUDENT HEALTH QUESTIONS (To be completed by student):

1. Are you required to or do you currently wear a health emergency bracelet? Circle: **Yes No**
2. Have ever been hospitalized or treated in an emergency room? Circle: **Yes No**
   (If yes, please provide treatment details to your health care provider completing your exam).
3. Are you currently taking any medication? Circle: **Yes No**
   (If yes, please list the medication(s), how often you take the medication(s), and the condition(s) being treated on a separate sheet.)
   - I have been provided with information on traveling with medication. I acknowledge that I will check on the availability of my medication in the country in which I will study and contact the study abroad office if I need assistance. I will also carry a copy of my medication list with me when I travel. I understand that shipping certain medications can be illegal and/or not reliable. **___ (initial)**

4. Are you currently receiving, or have you received in the past two years, counseling for any emotional problem, drug addition, alcoholism, psychiatric condition, or eating disorder? Circle: **Yes** **No**
   (If yes, please attach an additional form with details.)
5. Do you require accommodations such as extended time on exams, housing needs, assistive technology, or do you have a functional limitation that may limit or impede your ability to participate in this program? Circle: **Yes** **No**
   (If yes, please contact Accessible Education Services (AES) at UP in in Buckley Center 163, 503-943-8236.)

Authorization and Acknowledgement Regarding Student Health Information: (To be completed by the student)

Participation in a University of Portland study abroad program is contingent upon review of a student's completed health form. Studying abroad can be a physically and mentally challenging experience. Mild or pre-existing health conditions can become serious for some students as they transition into an unfamiliar culture and environment. Full disclosure of a student's health history is necessary for the Office of Studies Abroad, working in conjunction with the University Health Center, to assess health-related risks posed by participation in a study abroad program, to help prepare students for their study abroad experience, and, in an emergency, arrange for the provision of healthcare services.

☐ I hereby verify that all of the information contained in this form and any attachments I have provided is accurate and complete and that I have shared this information with my health care provider. I acknowledge that any failure to provide accurate and complete information may result in my dismissal from the study abroad program.

☐ I authorize the information contained in this form to be shared with the professional staff at the Office of Studies Abroad and the University Health Center for purposes of assessing health-related risks posed by my participation in the study abroad program, preparing me for my study abroad experience, and, if necessary, assisting me to obtain healthcare services.

☐ **I agree to notify the Office of Studies Abroad of any material changes in my health, affecting the accuracy or completeness of the information contained in this form or any attachments I have provided, that occur prior to the start of or during of the program. I acknowledge that any failure to provide such notice may result in my dismissal from the study abroad program.**

☐ In the event of an emergency, I authorize the Office of Studies Abroad and the University Health Center to disclose my relevant health information from this form, any attachments I have provided, and the Health Care Provider Form to my parents or other designated emergency contacts and appropriate treatment personnel. To the extent my health information includes mental health-related information, alcohol or substance abuse treatment information, and/or my HIV or other communicable disease status, I specifically authorize the Office of Studies Abroad and the University Health Center to disclose such information in the event of an emergency.

The information disclosed will be kept confidential in accordance with applicable law. Disclosure of your information will only be made to appropriate individuals, and handled with the highest levels of discretion in order to protect your privacy.

The conditions of this form have been explained to me and my questions have been satisfactorily answered.

This authorization is effective from the date indicated below and is valid until revoked. You may revoke this authorization by submitting a written request to the Office of Studies Abroad, but any such revocation shall not affect disclosures previously made by the University of Portland prior to the receipt of such written revocation.

Student signature _____ Date _____

Parent/Guardian signature if under 18 _____ Date _____

HEALTH CARE PROVIDER FORM (To be completed by health care provider):

This form is to be filled out by a licensed health care provider (MD, DO, NP, PA). It is to be mailed by that health care provider to the University of Portland Office of Studies Abroad.

Student's name: Date of birth:

Please perform a thorough physical evaluation of the student listed above. Review the student's responses to the student information section of this form (pages 1 and 2). This evaluation is required for his/her participation in a university sponsored overseas experience. This information may be vital if the student is involved in any emergency while overseas. You may attach an extra page if you need more room for any of your answers. Thank you for your help in this matter.

EXAMINATION DETAILS: The health care provider must complete all items in this box for the form to be accepted as complete.

Date of Examination: _____

Height: _____ Weight _____ Blood Pressure: ____/____ Pulse: _____ Resp: _____

MEDICATION(S)

If the patient is currently taking any medication that he/she will be bringing with him/her on the study abroad program, please provide details of all medication. In addition, please discuss with the patient means to obtain necessary supply of medicine while abroad.

Name of Medication	Prescribed for	Dose and frequency

Please attach an additional sheet if necessary

Country/Location of study abroad experience: _____

Other possible countries/locations: _____

Immunization record reviewed:

- ☐ Immunization records reviewed and attached
- ☐ Additional immunizations recommended by www.cdc.gov/travel (please list)

_____ _____ _____ _____

- ☐ Immunizations administered and VIS provided (attach documentation)
- ☐ Recommend consulting with a Travel Medicine Specialist due to area of travel

History and Physical Exam:

- ☐ Completed
- ☐ Pertinent Diagnosis: _____ _____ _____ _____

SUMMARY AND SIGNATURE

Is there any medical condition that currently affects this patient and may require follow-up care while the patient is abroad?

☐ YES: Please explain

☐ NO

Is there any psychological condition that is currently affecting this patient and may require follow-up care while this patient is abroad?

☐ YES: Please explain

☐ NO

With my signature below, I acknowledge the patient is physically and mentally able to participate in a study abroad program.

Signature of Health Care Provider: _____ Date: _____

Name of Health Care Provider (please print): _____ Title: _____

Address of Health Care Provider: _____

Phone Number: _____

Please return this entire International Travel Health Evaluation Form to:

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