INTERNATIONAL TRAVEL HEALTH EVALUATION FORM

STUDENTS READ THIS FIRST: Participation in a Moreau Center international immersion or internship 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 Moreau Center 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
Moreau Center 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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES or NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to medication</td>
<td>YES or NO</td>
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<tr>
<td>Allergies of any kind</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Anaphylactic Shock</td>
<td>YES or NO</td>
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<tr>
<td>Asthma</td>
<td>YES or NO</td>
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<tr>
<td>Cancer or tumors</td>
<td>YES or NO</td>
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<tr>
<td>Chronic respiratory problems</td>
<td>YES or NO</td>
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<tr>
<td>Chronic digestive/GI problems</td>
<td>YES or NO</td>
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<tr>
<td>Diabetes</td>
<td>YES or NO</td>
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<tr>
<td>Dietary restrictions</td>
<td>YES or NO</td>
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<tr>
<td>Dizziness/fainting spells</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Epilepsy or seizures</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Gastrointestinal trouble</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Head aches/migraine</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Head injury</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Heart or circulatory conditions</td>
<td>YES or NO</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>YES or NO</td>
</tr>
<tr>
<td>Jaundice/hepatitis</td>
<td>YES or NO</td>
</tr>
</tbody>
</table>

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 you 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 Buckley Center 163, 503-943-8236.)

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

Participation in a Moreau Center international immersion or internship is contingent upon review of a student's completed health form. Service learning, particularly in an international setting, 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 Moreau Center, working in conjunction with the University Health Center, to assess health-related risks posed by participation in an international immersion or internship, to help prepare students for their 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 Moreau Center program.

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

☐ I agree to notify the Moreau Center 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 Moreau Center program.

☐ In the event of an emergency, I authorize the Moreau Center 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 Moreau Center 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 Moreau Center, but any such revocation shall not affect disclosures previously made by the University of Portland prior to the receipt of such written revocation.

<table>
<thead>
<tr>
<th>Student signature</th>
<th>Date</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Parent/Guardian signature if under 18</th>
<th>Date</th>
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<tbody>
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</table>
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 Moreau Center at the University of Portland.

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 international immersion or internship, 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 immersion or internship: _______________________________________________________

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 currently affects 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 an international immersion or internship.

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:

University of Portland
MOREAU CENTER
5000 North Willamette Boulevard
Portland, Oregon 97203-5798
(503)943-7132/Fax: 503-943-8567
www.up.edu/moreaucenter