Messiah University Travel Health History - Part A

Responses on this form will assist your health care provider in establishing your safety for travel. Please answer the following questions completely and accurately.

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Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Contact Phone:	**Preferred Pharmacy:**	
Address:		
Email:	**Student ID:**	
Group:	**Travel Dates:**	
Travel Destination:		

PERSONAL HEALTH HISTORY

Immunizations and dates: **(Bold are University required)**	☐ **Tetanus** most recent:	☐ Hepatitis A 1. 2.
	☐ **Meningococcal** 1. 2.	☐ Hepatitis B 1. 2. 3.
	☐ **Varicella** 1. 2.	☐ Polio 1. 2. 3. 4.
	☐ **MMR** 1. 2.	☐ COVID most recent:

Check any mental or physical health problems that have been diagnosed

☐	Anxiety	☐	Depression	☐	Epilepsy/Seizure Disorder
☐	Arthritis	☐	Gastroesophageal Reflux Disease	☐	Kidney Problems
☐	Asthma	☐	Heart Problems	☐	Pregnancy
☐	Autoimmune disease	☐	Syncope/Dizzy/Fainting/ POTS	☐	Substance use disorder
☐	Bipolar Disorder	☐	Vertigo	**List any other diagnoses below**	
☐	Crohn's disease	☐	Diabetes	☐	
☐	Cancer	☐	Hearing issues	☐	
☐	PTSD/Trauma	☐	Gait (walking) problems	☐	
☐	Bleeding disorders	☐	Narcolepsy	☐	

List any medications you are currently taking

Medication	Dose

List your food, drug, or environmental allergies

Allergy	Reaction

Do you have any special dietary needs? (list below)	☐ Yes	☐ No

Messiah University Travel Health Clearance - Part B

Traveler Name _____Date of Birth_____

Traveler Phone Number _____ Traveler Email:_____

Dates of Travel:_____ Destination (s) :_____

Fill out the following after reviewing the Travax or CDC report or with the assistance of licensed medical staff:
I am traveling to an area where there is a moderate to high risk of the following illnesses (circle Yes/No)

Malaria: YES/NO Traveler's Diarrhea: YES/NO Typhoid: YES/NO Hepatitis A: YES/NO Yellow Fever: YES/NO

Other known illness risk: _____
I have received counseling and or preventative treatment for the above identified risks.

Traveler Signature: _____ Date: _____

Vaccine Certification

I certify that the patient's vaccine record reflects appropriate baseline coverage for the area of travel (including major relevant childhood vaccinations and any vaccines **required** by the destination of travel (e.g., Yellow Fever).
RN/NP/MD/DO/PA Signature_____ Printed Name_____
Date: _____

Provider Certification *(to be completed by a Physician, Nurse Practitioner, or Physician's Assistant)*

_____ I have reviewed the traveler's physical and mental health history form (part A) and see no medical condition or disability that would prevent the student from full participation in the travel plan as described by the student:
_____I have reviewed the traveler's physical and mental health history form and I recommend the following accommodations, actions, or specialist letters in order to allow participation in the travel plan:
_____
_____
_____
_____
_____ I have reviewed the traveler's physical and mental health history form and have reason to be concerned about how this person's physical or medical condition may be affected by the travel plan as described by the student. I do not recommend this travel.

Provider Name: _____

Provider Signature_____

Date__ /___/_____ *(office stamp)*