Messiah University Travel Health History - Part A

Responses on this form will assist your health care provider in establishing your safety for travel. The traveler should also provide the written trip description to the clearing provider. Please answer the following questions completely and accurately.

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

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 in the Traveler

	Anxiety, OCD, Panic Attacks		Depression	Epilepsy/Seizure Disorder
	ADHD or Autism		Gastroesophageal Reflux Disease	Kidney Problems/ Recurrent UTI's
	Asthma/ Respiratory condition		Heart or Blood Pressure problems	Pregnancy
	Autoimmune disease (e.g., Lupus, RA)		Syncope/Dizzy/Fainting/ POTS	Substance use disorder
	Bipolar Disorder/Mood disorder		Vertigo	**List other physical/mental health diagnoses below**
	Crohn's disease, or other Bowel disease		Diabetes	
	Cancer		Hearing issues	
	PTSD/Trauma		Gait (walking) problems	
	Bleeding disorders		Narcolepsy/Insomnia/Sleep Disorder	

List any medications you are currently taking, prescription or over the counter (include dose):

List any prior Surgeries or hospitalizations:

List your food, drug, pet, or environmental allergies (continue on back of page if needed)

Allergy	Reaction

Do you have any special dietary needs? (continue on back of page if needed)	☐ Yes	☐ No

Updated 11/2025

Messiah University High Risk Travel Health Clearance - Part B

This form should be submitted to the Trip leader prior to travel

Traveler Name _____DOB_____Phone_____

Dates of Travel:_____ Destination(s) :_____

Emergency Contact _____Phone_____

In the event local emergency care is needed abroad, please list the following information for your trip leader to provide to emergency personnel:

Allergies *(food, pet, med, other)* _____

Significant Health History:_____

Daily and/or Emergency Medications_____

_____

The area of travel has 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: _____

Vaccine Certification

I certify that the patient's vaccine record reflects appropriate baseline coverage for the area of travel (including major relevant childhood vaccinations (MMR, TDAP, Varicella, Hep A, etc.) and any vaccines **required** by the destination of travel (e.g., Yellow Fever).

Provider or RN Signature: _____Printed Name:_____ Date ___/___/_____

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

_____ **CLEARED FOR TRAVEL** 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.

_____ **CONDITIONALLY CLEARED** I have reviewed the traveler's physical and mental health history form and **I recommend the following accommodations, actions, or specialist letters be provided prior to participation in the travel plan**:

_____

_____

_____

_____ **NOT CLEARED FOR TRAVEL** 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)*