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

Messiah University Low-Risk Travel Health Clearance (Part B)

Traveler to submit per trip leader instructions.

Traveler Name _____ Date of Birth_____

Traveler Phone Number _____ Traveler Email: _____

Dates of Travel:_____ Destination (s) :_____

Emergency Contact Name_____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, drug, environmental) _____

Health History: _____

Daily and/or Emergency Medications_____

_____

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

Select from the following:

_____ **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 presented in the trip leader's description. The traveler's vaccine record reflects appropriate baseline coverage for the area of travel. Medications required for travel (*e.g.,* Traveler's Diarrhea treatment) have been prescribed as necessary.

_____ **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 presented with this form to the trip leader prior to travel.

Please attach or write on the back of this paper any emergency protocols that should be in place for this student (emergency medications like epi-pen, protocols for psychiatric emergencies, asthma plan, etc.)

_____ **NOT CLEARED** 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 Signature: _____

Printed Name, Credentials: _____

Date__ /___/_____ *office stamp*