

## STUDENT PRE-TRAVEL HEALTH INFORMATION FORM

The purpose of this form is to help Lee College to be of maximum assistance during your travel experience. It is important that the program be made aware of any medical condition that could impact our health during a trip. The information provided will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if necessary to your wellbeing. Lee College may not be able to accommodate all individual needs or circumstances. This information does not affect your admission for the trip.

Student's Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_F \_\_\_\_M

Program: \_\_\_\_\_ Country: \_\_\_\_\_

Semester: \_\_\_\_\_

### Immunization Records

<b>Vaccine</b>	<b>Date</b>	<b>I have not had this vaccine</b>
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Chicken Pox (Varicella) Tetanus/	_____	_____
Diphtheria	_____	_____
Polio	_____	_____

### General Health Information

1. Are you generally in good physical condition? (If no, please attach explanation) \_\_\_\_ Yes \_\_\_\_ No
2. Do you have any allergies? (If yes, please attached explanation.) \_\_\_\_ Yes \_\_\_\_ No
3. Are you taking any medications? (If yes, please attach explanation.) \_\_\_\_ Yes \_\_\_\_ No
4. Have you had major injuries, diseases, or ailments in the past five years? (If yes, please attach explanation.) \_\_\_\_ Yes \_\_\_\_ No
5. Are you a vegetarian or are you on a restricted diet? (If yes, please attach explanation.) \_\_\_\_ Yes \_\_\_\_ No
6. Is there any additional information (concerning medical conditions, or physical disabilities) that would be helpful for the program to be aware of during your trip experience? (If yes, please attach explanation.) \_\_\_\_ Yes \_\_\_\_ No

### Release of Medical Information:

I hereby authorize Lee College and its duly authorized representatives to release, in accordance to HIPAA standards, during my participation in the program, personal information concerning my physical and/or emotional health to my parent(s) or legal guardian(s) and to individuals assisting with medical communications for Lee College.

I further authorize Lee College and its duly authorized representatives to contact any of the individuals listed below to provide them with medical information in the event that I need medical care or evacuation while I am overseas:

List name(s) of person(s) and their contact information (**Name, Relationship, Phone Number(s), E-mail Address, and Mailing Address**) to release medical information to:

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**I certify that all responses made on this Health Information form are true and accurate, and I will notify the Program's Lead Faculty hereafter of any relevant changes in my health that occur prior to the start of the program.**

**Signature of participant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian's signature (if student is under the age of 18):

\_\_\_\_\_ **Date:** \_\_\_\_\_

In the event of an emergency, illness or injury affecting (my son, my daughter, my ward, or myself),

\_\_\_\_\_ (student's name), born (date) \_\_\_\_\_, the

undersigned hereby authorizes immediate hospitalization and treatment recommended by and carried out under the supervision of a qualified physician, including administering anesthetic and performing necessary surgery. Provide the following information:

- **HEALTH INSURANCE INFORMATION: Attach a copy (front and back) of insurance card**
- **Physician/Clinic/HMO: Name & Phone Number:**

\_\_\_\_\_

- **Emergency Contact: Name and Relationship** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

Known allergies to medication:

\_\_\_\_\_

Student's blood type, if known: \_\_\_\_\_

**Signature of participant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian signature (if student is under age 18): \_\_\_\_\_ **Date:** \_\_\_\_\_