STONEHILL COLLEGE

Stonehill College Domestic and International Travel/Study Programs | 2018-2019 Pre-Travel Medical Screening FORM A

Domestic and international travel programs can be physically and emotionally demanding and clinical resources may be limited at some locations. The intention of this medical review process is to help you anticipate your medical needs and enable you and your clinician to formulate a plan of support and care during your travels. Health Services recommends you consult with your PCP and/or a Travel Clinic and the CDC travel site for health notices and recommendations regarding your itinerary. After completing PART 1 of this form, present it to your primary care provider for review and completion of PART 2. Once you have received completed documentation from your primary care provider (and mental health provider(s) if applicable), return completed FORM A to Health Services in person, by fax (508-565-1510), or by mail. **FORM A must be received in Health Services at least 60 days prior to travel.** For questions, call Health Services at 508-565-1307. Please answer "YES"/"NO" questions by circling your answer.

PART 1: To be completed by student (applicant)

Name		Program Name	
Date of Birth Class Year		Program Location(s)	
Phone		Departure Date/ Return Date	

Do you have any allergies to medications, foods, insects, pets or "other"? YES NO
If yes, please list:

Are you taking any prescription medication regularly or on an as needed basis? YES NO
If yes, please list below (please include Epi Pens and Inhalers):

- While traveling, all medications should be placed in your carry-on luggage in the original prescription packaging.
- Please remember to bring as needed medications, such as Inhalers and Epi Pens with you on your trip.
- Please ensure you have an ample supply of medication with timely expiration dates so medication will last for duration of trip and will not expire while traveling.

Medications:

List your medical history including any chronic or current medical conditions, diseases, significant injuries, hospitalizations or surgeries in the past 5 years. If no medical history, please write "NONE"

Does your health keep you from participating in any physical activities? YES NO
If yes, please describe:

Have you been under the care of a psychiatrist, psychologist, therapist /counselor in the past 5 years for a mental health issue? YES NO
Have you ever been prescribed psychiatric medication? YES NO
If yes, please describe mental health issue and list any medications:

Is there anything about your health/medical history that may be a factor in an emergency? YES NO
If yes, please explain:

Stonehill College Health Services recommends a consultation with a Travel Clinic to discuss destination-specific guidance.

- We recommend participants traveling internationally access destination-specific health, safety and immunization related information on the Center For Disease Control (CDC) website: https://wwwnc.cdc.gov/travel. Many countries require specific immunizations.
- All students traveling to developing countries are advised to consult with a Travel Health Clinic regarding immunization and healthcare recommendations prior to travel.
- Please note Travel Clinics usually require an appointment to be booked at least 4-6 weeks prior to travel. Since some immunizations/medications need to be started 4-6 weeks prior to travel, it is important to book an appointment early in the process.

I certify I have read and understand this form in full. I certify the information I have provided within this form is complete and accurate and I give permission for the information on any page of this form to be shared with College officials and medical providers in connection with my travel program. By completing this form and submitting to my healthcare provider, I certify that I have discussed my travel program with my healthcare provider and have a plan in place for any medical concerns while traveling. I am aware Health Services advises all international travelers to consult with a travel clinic 4-6 weeks prior to traveling and I have reviewed CDC travel recommendations for travel destination(s). I understand that in order to participate in a Stonehill Travel Program my routine immunizations need to be up to date.

Applicant (Student) Signature: ____ Date:____/_____/20_____

Student Name:__________________________________

PART 2: To be completed by applicant's Primary Care Physician after review of PART 1 of this form.

Please review all of the bulleted points and check the box that applies to clear for travel:

☐ STUDENT IS CLEARED

- There are no medical or mental health contraindications to participation in the program the student has chosen.
- The student is up to date on all routine immunizations.
- Student has a treatment plan ensuring sufficient supply of prescribed medications and health care supplies for duration of program.
- Student has a plan should they have an acute exacerbation of any of their chronic medical/psychiatric conditions.
- If applicable, student's medical/psychiatric condition has been stable.

☐ STUDENT IS NOT CLEARED

- Student requires additional services to facilitate safe participation in the program. (*Please provide additional information below)*
- There are medical or mental health contraindications to safe participation in the program. (*Please provide additional information below*)

Additional Information:	
Name of Licensed Physician/Primary Care Provider:	Provide address or place office stamp here:
Signature:	
Date: / /20	Phone Number:

Completed FORM A should be returned to Stonehill College Health Services by mail, in person or by fax
AT LEAST <u>60 DAYS</u> PRIOR TO DEPARTURE DATE.

Stonehill College Health Services
320 Washington Street – Easton, MA 02357
508.565.1307 (phone) – 508.565.1510 (fax)

For Stonehill College Health Services Administrative Use Only:

☐ The required documentation has been reviewed and the documentation supports student's application for participation in the program.

☐ The required documentation has been reviewed and we find there may be medical/psychiatric contraindication to participation in the program.
- ☐ The student is advised to call Health Services at 508-565-1307 to further discuss**.**
- ☐ The student may not participate without further supporting documentation from their healthcare provider(s).

☐ The required documentation has been reviewed and the student's documents indicate the student has NOT been cleared for participation in the program.

Notes:____

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Stonehill Clinician Name:____

Stonehill Clinician Signature:_______________________________________ Date:_____/_____/20___