International Travel: Wellness Report

Please read before completing this form:

This required information is to be completed by the participant and is designed to help the Center for Global Education(CGE) be of maximum assistance to you during your study abroad experience should the need arise. Mild physical or psychological conditions can become serious under the stresses of life while studying abroad. Thus, it is important that the program be aware of any medical or emotional conditions, past or current, which might affect you while abroad. The information on this form will be shared as follows: definitely with CGE staff and the Edgewood College Health Center; as deemed necessary with the director(s)/coordinator(s) for your study abroad program and health care providers. **It does not affect your admission to the program.**

***Study abroad sites may not be able to accommodate all reported individual needs or circumstances. If you do not report a health condition, our ability to assist you in case of an emergency may be compromised.**

Name: (First, Last)_____ **Date of Birth:**_____ **Gender:**_____

Study Abroad Program:_____ **Term Abroad:**_____

Departure Date:_____ **Return Date:**_____ **Countries to be visited:**_____

Please note below any *conditions* you have:

☐ YES	☐ NO	Asthma	☐ YES	☐ NO	HIV/AIDS, other immune disorder, leukemia or cancer
☐ YES	☐ NO	Neurologic Condition (convulsion, epilepsy, brain infection)	☐ YES	☐ NO	Organ Recipient (If yes, list organ below) _____
☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Chronic kidney problems
☐ YES	☐ NO	High Blood Pressure or any heart disease with or without symptoms	☐ YES	☐ NO	Pregnant or might become pregnant on this program abroad
☐ YES	☐ NO	Chronic Gastrointestinal Condition (ulcers, chronic diarrhea or colitis)	☐ YES	☐ NO	Low platelet count, bleeding problem or clotting disorder
☐ YES	☐ NO	Active mental health issues that require counseling or medication (depression, anxiety, eating disorders, etc.)			

Are you taking any medication? If so, please list and provide reason for taking.

Do you anticipate needing any health care or mental health treatment while abroad? If yes, please describe.

Is there any other condition that would be helpful for the program to be aware of during your study abroad experience? If yes, please explain.

If YES to any conditions listed above or traveling longer than 6 weeks, it is your responsibility to schedule an appointment with a health care provider prior to travel AND have the provider sign page 2 of this form

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Center for Global Education

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Schedule an appointment with a health care provider ideally 8 weeks prior to travel to see if you need any routine or travel vaccinations or medications (diarrhea/anti-malaria).

ROUTINE VACCINES	***HAD DISEASE (list dates if known)***	***VACCINATION HISTORY (list dates if known)***
Measles (rubeola), Mumps, German measles (rubella)		MMR 1) 2)
Chicken Pox (varicella)		1) 2)
Meningococcus (meningitis, *not* HIB)		[ ] Menactra (MCV4) (/) [ ] Menomune (MPSV4) mo / yr
Pneumococcus (pneumonia)		
Flu shot (influenza)		
Hepatitis A (two shot series *or* may be combined with B) Hepatitis B (three shot series)		1) 2) 1) 2) 3)
Tetanus, Diptheria, Pertussis (e.g. Td, Tdap)		Most recent (mo/yr): (/)
Polio: Have you received at least 3 doses of polio vaccine, including childhood doses?		Most recent (mo/yr): (/)
POSSIBLE TRAVEL VACCINES: Rabies, Typhoid, Japanese Encephalitis, Yellow Fever		

ALLERGIES: Do you have any allergies to food, medication, environmental factors, insects etc.? If yes, what happens when you come in contact with the allergen?	

List the provider or mental health professional(s) that Edgewood should contact in case of an emergency:

Provider Name: _____ Provider Name: _____

Contact Info: _____ Contact Info: _____

I certify that all responses made on this Wellness Report are true and accurate, and I will notify the CGE and Program Director hereafter of any relevant changes in my health that occur prior to the start of the program. I understand that the information on this form will be shared as follows: definitely with CGE staff and the Edgewood College Health Center; as deemed necessary with the director(s)/coordinator(s) for your study abroad program and health care providers. This form is for information purposes only and in no way implies that the program director, health care provider or any other Edgewood College staff member takes responsibility for my health.

Participant Signature: **Date:**

PROVIDER SIGNATURE REQUIRED IF
ANSWERED YES TO ANY CONDITIONS *OR* TRAVELING LONGER THAN 6 WEEKS

Provider Use Only--the following topics were reviewed:

☐ **Routine/Travel Vaccinations** ☐ **Current Health Condition(s)** ☐ **Current Medication(s)** ☐ **Travel Medication(s)**

☐ **General Travel Info/Safety** ☐ **Other** _____

Provider Name (print): _____

Provider Signature: **Date:**