Saint Mary's College of California Travel Health Form

Page 1: To be completed by the student prior to visiting their Healthcare Provider:

Name: ____________________ Date of Birth: ____________ SMC ID Number: ______________

Destination: __________________ Professor: _____________ Dates of Travel: _______________

The travel itinerary for this class and/or destination(s) has been reviewed:
(*Please complete at the appointment with your Healthcare Provider and attach a copy of the itinerary, if applicable*)

Patient Signature: ____________________ Clinician Signature: ______________

Medication Allergies and reaction: ____

Environmental Allergies and reaction: ____

Current Medication	Dosage

Check whether you have had any of the following conditions. If yes, please describe:

Yes	No	Condition	Yes	No	Condition
☐	☐	ADD/ADHD ______	☐	☐	Hernia ______
☐	☐	Anemia ______	☐	☐	High blood pressure ______
☐	☐	Allergies, Hay Fever ______	☐	☐	Irregular menses ______
☐	☐	Asthma ______	☐	☐	Irregular heartbeat or Extra beats ______
☐	☐	Diabetes ______	☐	☐	Kidney or Bladder problem ______
☐	☐	Depression or Anxiety ______	☐	☐	Mononucleosis (Mono) ______
☐	☐	Drug or Alcohol Dependency ______	☐	☐	Physical disability ______
☐	☐	Eating Disorder ______	☐	☐	Significant illness/injury ______
☐	☐	Epilepsy or Seizures ______	☐	☐	Thyroid Disorder ______
☐	☐	Fainting or Passing Out ______	☐	☐	Ulcers, Stomach problem, Colitis ______
☐	☐	Gynecologic Disorder ______	☐	☐	Weight loss/gain greater than 10 lbs. ______
☐	☐	Head Injury, Concussion ______	☐	☐	Past surgeries ______
☐	☐	Headaches ______	☐	☐	Other, please describe ______

Are you currently under the care of a doctor or other health care professional, including mental health? Yes or No

Explain: ____

If you have a disability for which you would like accommodations, please contact Student Disability Services at 925-631-4358 or sks@stmarys-ca.edu.

I hereby authorize the release of the information included on this form to the Saint Mary's College Jan Term Office. The above information is complete and accurate to the best of my knowledge.

Student Signature ____________________ Date: ______________________

Name____________________________ Date of Birth ___________________

To be completed by the Healthcare Provider:

Vital signs: BP__________ Pulse __________ Wt. ____________

Immunization/Vaccine record:

Hepatitis A (2 doses): 1.__________ 2.__________
Month/Year Month/Year

Hepatitis B (3 doses): 1.__________ 2.__________ 3.__________
Month/Year Month/Year Month/Year

Influenza Vaccine (given annually): ________
Month/Year

Meningococcal: __________
Month/Year

MMR (2 doses): 1.__________ 2.__________
Month/Year Month/Year

Polio Vaccine (4 doses): 1.__________ 2. __________ 3. __________ 4.__________ Adult Polio Vaccine: __________
Month/Year Month/Year Month/Year Month/Year Month/Year

Tetanus or Tdap Booster (Last dose given): __________
Month/Year

Typhoid (Please indicate if oral or IM): __________ Oral or IM: __________
Month/Year

Varicella: (date of disease, antibody titer or 2 vaccinations) 1. __________ 2. __________
Month/Year Month/Year

Japanese Encephalitis: __________ Yellow Fever: __________
Month/Year Month/Year

CDC (Center for Disease Control) recommended immunizations for travel: ______________________________

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Plan: ____

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I have reviewed the medical information provided on the Health Travel Form and find that the student: *Check one*:

- ☐ The student has no medical condition precluding participation in SMC Jan Term travel.
- ☐ The following information should be shared with Professors or College officials to assist while traveling:
  Serious active or chronic condition: ____
  Critical medication and dosage: ____
  Allergies: ____
  Suggested accommodations due to disability: ____
- ☐ In my professional opinion, the student should not participate in a student abroad program.
- ☐ The student requires the signature of their primary physician and/or specialist(s) for an ongoing condition.

Clinician's Signature: ____________________________________ Date: ____________________________

Specialist Signature (if required)_____________________________Date________________Specialty________________