



Name: _____ Sex: M/F DOB: _____ Age: _____

Address: _____ Phone: _____

Purpose of Travel: School Related Study: _____ School Related Work: _____ Other: _____

If School Related, What Program? _____

Specific Activities Planned: _____

Date Leaving the United States: _____ Date Returning to United States: _____

Countries Planning to Visit: _____

Where will you be traveling/visiting/staying? (Mark all that Apply)

Cities: _____ Countryside: _____ Village: _____ Family: _____ Friends: _____ Hostels: _____ Hotels: _____ Other: _____

| Will you be doing any of the Following? | | | Immunization History | | |
|---|----|--|----------------------|----|--|
| Yes | No | | Yes | No | |
| | | Working with Animals | | | Were you born and raised in the US? |
| | | Going to Altitude, >6500 Feet | | | Did you receive all of your childhood immunizations (shots)? |
| | | Possibly having sexual contact with new partners | | | Have you had the Hepatitis A Series? |
| | | Working in an environment with exposure to blood or other body fluids? | | | Have you had an influenza shot this year? |

What year was your last Tetanus Shot? _____

Do you have any drug allergies? Yes: _____ No: _____ Penicillin: _____ Aspirin: _____ Bactrim: _____ Septra: _____

If yes, list the Medication Name AND Allergic Reaction you had: _____

Do you have Food allergies? Yes: _____ No: _____ Eggs: _____ Quinines: _____

If yes, what Foods? _____

Have you ever had Surgery? Yes: _____ No: _____ If yes, explain: _____

Do you have any Surgical Procedures between Now and your Date of Travel? Yes: _____ No: _____

If yes, explain: _____

List your current Prescription Medications and the Medical Condition Treated AND list Regularly Used Non-Prescription Medications (over-the-counter, herbals, vitamins, nutrition supplements):

Medication Name

Medical Conditions



Have you been **diagnosed** with any of the following medical conditions (*mark YES or NO*) **OR** is there a history of these medical conditions in your family (*mark FAM HX*)?

| YES | NO | FAM HX | | YES | NO | FAM HX | | YES | NO | FAM HX | |
|-----|----|--------|--|-----|----|--------|--|-----|----|--------|----------------------------|
| | | | Abnormal Bleeding Tendency | | | | Depression/Anxiety | | | | Lung Disease |
| | | | Alcohol/Drug Dependency | | | | Diabetes | | | | Malaria |
| | | | Anemia | | | | Epilepsy/Seizures | | | | Other Mental Health Issues |
| | | | Anorexia/Bulimia | | | | G6PD Deficiency | | | | Psychological Problems |
| | | | Arthritis | | | | GI or Stomach/Intestinal Issues | | | | Severe Visual Problems |
| | | | Asthma | | | | Gall Bladder or Liver Disease | | | | Sickle Cell Trait/Disease |
| | | | Attention Deficit Disorder (ADD or ADHD) | | | | Head Injury/Concussion | | | | Thyroid Disease |
| | | | Blood Clotting Problems | | | | Heart Disease or Murmur | | | | Under/Over Weight |
| | | | Cancer | | | | Hepatitis or Liver Disease | | | | Other: |
| | | | Chronic Back Problems | | | | High Blood Pressure | | | | |
| | | | Chronic Skin Problems | | | | Immune System Deficiency (Autoimmune Deficiency) | | | | |
| | | | Colitis or Colon Problems | | | | Kidney Disease | | | | |

IF you answered **YES** to any of the above, please give an explanation. State whether your condition is well controlled and what medications you are taking for it: _____

Clearance Option: (for the providers only)

I have reviewed the student's health history information provided to me, to the best of my knowledge, the student is:

- _____ **Medically Cleared to travel/study abroad. There are no contraindications identified at this time*.**
- _____ **Not Medically Cleared to travel/study abroad until separate clearance by a mental health provider.**
- _____ **Not Medically Cleared to travel/study abroad**
 - _____ There ARE contraindications to participation.
 - _____ More information is needed before a final decision can be made.
- _____ **Cleared to travel/study abroad but with the following stipulations:**
 - _____ Take medications with you including inhaler.
 - _____ If on birth control pills/patches/Nuva Ring, take aspirin before flights, increase fluids, and move around.
 - _____ If you plan to be sexually active with new partners, please bring condoms and discuss contraceptive options as well as Hep B immunization with provider.
 - _____ Other: _____

Healthcare Provider's Signature: _____ Date: _____
 Printed Name: _____ Physician/NP/PA

If seen at an outside clinic, please return to:
 Texas Tech University
 Office of International Affairs
 601 Indiana Ave. MS 5004
 Lubbock, TX 79409-5004

*Medical clearance may be rescinded due to unforeseen medical conditions.