Travel Physical Exam

General Information

Name:_____ DOB:_____/_____/_____
Study Abroad Advisor:_____ Advisor Email: _____
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 (not including flights)			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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Medical History

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				Psychological Problems
			Anorexia/Bulimia				G6PD Deficiency				Severe Visual Problems
			Arthritis				GI or Stomach/Intestinal Issues				Sickle Cell Trait/Disease
			Asthma				Gall Bladder or Liver Disease				Thyroid Disease
			Attention Deficit Disorder (ADD or ADHD)				Head Injury/Concussion				Under/Over Weight
			Blood Clotting Problems				Heart Disease or Murmur				Other Mental Health (Autism, Asperger's, Schizophrenia, etc.)
			Cancer				Hepatitis or Liver Disease				
			Chronic Back Problems				High Blood Pressure				Other:
			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.