Ball State University
Amelia T. Wood Health Center
Pre-Travel Assessment Form

Please complete this form prior to the appointment for your travel abroad physical

Name:_____Date of Birth:_____

Dates of Trip:

Departure Date: _____ Return Date:_____ Overall Length of Trip_____

Trip Itinerary:

City	Provence/Region	Country	Length of stay in area
1.			
2.			
3.			
4.			
5.			
6.			

Type of Trip:

1. Will you be traveling alone, with family/friends or in a group?_____

2. What activities do you plan to do while traveling? (examples:working in medical/dental field, working with animals/birds, outdoor activities such as hiking/camping, snorkeling/scuba diving)_____

3. Will you be staying in areas that are urban, rural, high altitude or other?_____

4. What type of accommodations will you have? (modern hotel, with local family, hostel, tent/cabin?)_____

Medical History

Please list any ongoing or past medical problems:

_____
_____
_____

1.Do you have any conditions treated with immunosuppressive drugs such as: cancer, organ transplant, rheumatoid arthritis, ulcerative colitis, crohn's disease, lupus, HIV, etc. _____

2.Do you have a history of mental illness including depression or anxiety?_____

3.Have you recently been treated with steroids?_____

4.Women only: are you pregnant, planning pregnancy or breastfeeding?_____

5.Do you have any allergies, for example to eggs, medications or nuts?_____

6.Have you ever had a serious reaction to a vaccine in the past?_____

7.Have you ever used malaria medication in the past? If so, what and when?_____

Please list all prescription, over-the-counter, birth control, vitamins and supplements that you are taking and dosages_____
_____
_____

Travel Immunization history

Typhoid-oral or injection, date_____

Yellow fever, date_____

Hepatitis A, dates_____

Hepatitis B, dates _____

Adult polio booster, date_____

Meningococcal, date_____

Japanese Encephalitis, dates_____

Rabies, dates_____

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BALL STATE UNIVERSITY

Office of Study Abroad

Health Evaluation

Congratulations on your acceptance into a Ball State University study abroad program. We want to help make this a safe and healthy experience. The purpose of this form is to help the Office of Study Abroad provide appropriate assistance to you should the need arise during your study abroad experience. We recommend you complete this form with the assistance of your current primary care provider or one at the Health Center who can best advise you regarding your health concerns.

Please list any allergies, dietary restrictions or special accommodations needed to fully participate in the program:

_____
_____

Physician/Nurse Practitioner

Name:_____ has applied for admission to a Ball State University study abroad program. In order to be eligible for the program, all applicants must receive certification indicating that the student is in good health and fully capable of participating in a study abroad program.

In your opinion, are there any medical and/or mental health issues that would preclude this student's successful participation in a study abroad program? Yes_____ No_____

Additional Comments: _____

_____
_____

Date of Examination:_____

Signature of Attending Physician/Nurse Practitioner_____

Printed name_____