Hamilton Travel Abroad Health Screening Form

Name ________________________________ DOB ____________________________________

Class ________________________________ Country of origin __________________________

College sponsoring program: ____

Purpose of visit: ____

Education _______ Travel _______ Volunteer work _______

Country/countries to be visited (please list all countries and dates of travel)

Country name	Arrival date	Departure date	urban	rural	hotel	dorm	family

Planned Activities	Climbing	Hiking	Scuba	Health care exposure	Animal contact	Childcare

Medical information

Allergies	Name		Reaction Type
Medications			
Seasonal			
Foods			
Insect			

Medications: please list all prescription, over the counter and supplements that you take				
Name	Reason for taking	Dose	Frequency	Intend to take while abroad

Women		
Last menstrual cycle		
Last Pap smear		
Gynecological problems		
Contraception taken?	Type	Dose

Are you or have you been under the care of a medical or mental health provider in the past 3 years?

If yes, please list condition(s)

I, ______________________________, an applicant for the Hamilton Study Abroad Program, give permission for this information to be shared between the Hamilton Study Abroad Program office, the Resident Director of the Hamilton Study Abroad Program in ___________________________, and with the Hamilton Health Center where applicable.

Student Signature: ____ Date: ____________________

Screening Questionnaire

Please check any of the following conditions that you have had treated in the past 3 years **Comment in space provided if currently treated for this condition or if resolved.**	
Severe allergy	
Immune disorder/HIV	
Blood disorder/cancer	
Autoimmune disease (lupus, rheumatoid arthritis	
Seizure or neurologic/movement disorder	
Gastrointestinal disorder (celiac, IBS, Crohn's etc)	
Cardiac disease/arrhythmia/history heart surgery	
Kidney disease/frequent UTI's	
Gynecological or urogenital disease	
Mental health problem (anxiety, depression, bipolar, schizophrenia, addiction)	
Eating disorder (anorexia, bulimia, overeating etc)	
G6PD deficiency	
Splenectomy (spleen removed)	
Please list any previous surgeries:	
Please list any medical conditions that require special testing or follow up while abroad	

The information I have provided is accurate and true to the best of my knowledge.
Signed:_________________________________ Date:____________________________________
Reviewed by: ___________________________ Date: ____________________________________

Physical Exam