

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my travel recommendations may contain personal health information based on my specific medical history and location of travel program and/or destination.

Phone number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dusty email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAVEL QUESTIONNAIRE** **must be completed by all students who are participating in a TAMIU sponsored travel abroad study program. By completing this form, you certify that all information provided is true and accurate.**

**Physical Exam**: Are you participating in an Affiliate or other study abroad program (such as ISA) that requires a physical exam conducted by a doctor as a part of your program requirement? YES NO

**Travel Itinerary**: LIST ALL COUNTRIES you might visit during your travel abroad program. Please include any layovers in South America or Africa if they are > 12 hours in duration.

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| --- | --- | --- | --- |
| Country (list all you may visit) | City or Region in each Country | Arrival Date | Departure Date  |
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**Medical History: REQUIRED FOR ALL TRAVELERS**. Indicate with a ✓ whether YOU have ever been diagnosed or treated for any of the following conditions. If more information is required, you may be contacted by a campus healthcare professional.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Positive TB skin test |  | ADHD/ADD |  | Thyroid disorder  |  |
| Heart Problems |  | Migraine Headaches  |  | Pregnant  |  |
| Seizures/Epilepsy |  | Sickle Cell Anemia  |  | Spina bifida |  |
| Asthma  |  | Diabetes  |  | Multiple sclerosis |  |
| Bipolar Disorder |  | Splenectomy  |  | Cerebral palsy |  |
| Depression |  | Immune deficiency  |  | Vertigo  |  |
| Anxiety/Panic Attacks  |  | Cancer  |  | Severe allergies (sinus) |  |
| OCD |  | Blood clotting disorder |  | Severe allergy to insects  |  |
| Visual impaired/blind |  | Arthritis  |  | Severe allergy to food  |  |
| Hearing impaired  |  | COPD |  |  |  |

**Medical Conditions**, not indicated above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications** currently taken (Prescribed and over the counter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies & Reactions** to medications, foods, insects, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunization History: ALL STUDENTS ARE REQUIRED TO SUBMIT A COMPLETE VACCINE RECORD ALONG WITH THIS FORM.** ***You can obtain a copy of your vaccine record from your high school, previous university or your physician’s office.***

**I UNDERSTAND THAT COMPLETING THIS FORM AND THE SUBSEQUENT ONLINE TRAINING SESSION IS NOT A MEDICAL CLEARANCE FOR TRAVEL. IF I HAVE A CHRONIC MEDICAL CONDITION THAT REQUIRES MEDICATION TREATEMENT OR AM BEING TREATED FOR MENTAL HEALTH PROBLEMS, I WILL DISCUSS MY CARE DURING TRAVEL, HOW TO HANDLE WORSENING OF MY SYMPTOMS OR IF I NEED TO AVOID TRAVEL WITH MY PRIMARY CARE PHYSICIAN PRIOR TO MY DEPARTURE.**

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_