SAINT MARY'S COLLEGE
STUDENT HEALTH CENTER

Saint Mary's College of California Travel Health Form

Page 1: To be completed by the student prior to visiting their Healthcare Provider:

Name: _____ Date of Birth: _____ SMC ID Number: _____

Destination(s): _____ Semester of Travel: _____

Medication Allergies and reaction: _____

Environmental Allergies and reaction: _____

Current Medication	Dosage

Check whether you have had any of the following conditions. If yes, please describe:

Yes	No		Yes	No	
☐	☐	ADD/ADHD _____	☐	☐	Hernia _____
☐	☐	Anemia _____	☐	☐	High blood pressure _____
☐	☐	Allergies, Hay Fever_____	☐	☐	Irregular menses_____
☐	☐	Asthma_____	☐	☐	Irregular heartbeat or Extra beats _____
☐	☐	Diabetes _____	☐	☐	Kidney or Bladder problem _____
☐	☐	Depression or Anxiety_____	☐	☐	Mononucleosis (Mono) _____
☐	☐	Drug or Alcohol Dependency _____	☐	☐	Physical disability _____
☐	☐	Eating Disorder _____	☐	☐	Significant illness/injury _____
☐	☐	Epilepsy or Seizures_____	☐	☐	Thyroid Disorder _____
☐	☐	Fainting or Passing Out _____	☐	☐	Ulcers, Stomach problem, Colitis _____
☐	☐	Gynecologic Disorder _____	☐	☐	Weight loss/gain greater than 10 lbs. _____
☐	☐	Head Injury, Concussion _____	☐	☐	Past surgeries_____
☐	☐	Headaches _____	Other, please describe_____		

Are you currently under the care of a doctor or other health care professional, including mental health? Yes or No

Explain: _____

If you have a disability for which you would like accommodations, please contact Student Disability Services at (925) 631-4358 or sks@stmarys-ca.edu.

Travel destination(s) have been reviewed:

Please sign at the appointment with your Healthcare Provider, once your travel destination(s) have been reviewed, to ensure that destination specific health risks and preventative measures have been reviewed.
I hereby authorize the release of the information included on this form to the Saint Mary's College Center for International Programs Office. The above information is complete and accurate to the best of my knowledge.

Student Signature _____ Date: _____

Name_____ Date of Birth _____ Destination: _____

Page 2: To be completed by the Healthcare Provider: Vital signs: BP_____ Pulse _____ Wt. _____

Immunization Record:
Provider, please check all recommended by CDC for travel destination (https://wwwnc.cdc.gov/travel/destinations/list)

☐ Tetanus or Tdap Booster (Last dose given): _____ Month/Year ☐ Influenza (given annually): _____ Month/Year

☐ Hepatitis A (2 doses): 1._____ Month/Year 2._____ Month/Year ☐ COVID 19: _____ Month/Year

☐ Hepatitis B (3 doses): 1._____ Month/Year 2._____ Month/Year 3._____ Month/Year

☐ MMR (2 doses): 1._____ Month/Year 2._____ Month/Year ☐ Meningococcal: _____ Month/Year

☐ Polio Vaccine (4 doses): 1._____ Month/Year 2. _____ Month/Year 3. _____ Month/Year 4._____ Month/Year Adult Polio Vaccine: _____ Month/Year

☐ Varicella: 1. _____ Month/Year 2. _____ Month/Year OR History of disease: _____ Year

☐Typhoid: _____ Month/Year Oral or IM ☐ Oral Rx sent to _____
Complete 4 doses (one tablet every other day) at least 10 days prior to travel. If getting injection, obtain at least 2 weeks prior to travel

☐Japanese Encephalitis: 1._____ Month/Year 2. _____ Month/Year **Obtain 2nd shot at least 1 week prior to travel**

☐Yellow Fever: _____ Month/Year **Obtain at least 10 days prior to travel**

☐Malaria Rx sent to _____ Pharmacy **Start taking one pill daily 1 - 2 days prior to travel to Malaria prone area and continue for 7 days after return**

☐Rabies: 1._____ Month/Year 2._____ Month/Year 3._____ Month/Year **2nd does within 7 days of first injection. 3rd provides lifetime protection if given within 3 years of first.**

Plan (always check updated CDC travel guidelines/recommendations for your destination prior to travel):

_____

_____

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I have reviewed the medical information provided on the Health Travel Form and find that the student: *Check one*:

☐ The student has no medical condition precluding participation in SMC travel.

☐ The following information should be shared with Professors or College officials to assist while traveling:
Serious active or chronic condition: _____
Critical medication and dosage: _____
Allergies: _____
Suggested accommodations due to disability: _____

☐ In my professional opinion, the student should not participate in a study abroad program.

☐ The student requires the signature of their primary physician and/or specialist(s) for an ongoing condition.

Clinician's Signature: _____ Date: _____

Specialist Signature (if required): _____ Date: _____ Specialty: _____