Haverford Student Health Services

Travel Health Questionnaire

Form must be completed prior to scheduled appointment.

Background

Date:
Name:
Student ID (include zeros):
DOB:
Travel Consultation Date:

Travel History

Country of Origin:
Date of Departure from USA:
Date of Return to USA:

Itinerary

Countries of Destination	Date of Arrival	Approx. Length of Stay

Travel Type check all that apply

☐ Guided Tour	☐ Unusual Tourist Areas	☐ Independent Travel
☐ Major Cities	☐ Fixed Itinerary	
☐ Usual Tourist Areas	☐ Flexible Itinerary	
Location/ Type of Housing:		
Are you traveling with a Haverford affiliated group such as CPGC or with another organization/ program?		

Have you traveled abroad in the past? ☐ Yes ☐ No **IF YES**, where?
What will be your water supply?
Do you know how to purify your drinking water?
Do you have a source of healthcare overseas?

Health Insurance

Does your current medical insurance cover you for illness outside of USA?

☐ Yes ☐ No ☐ Not Sure

You are responsible for insurance coverage.
If you need international coverage please visit our affiliated website at:

http://www.firststudent.com/school_detail/travel-assistance-evacuation-repatriation-haverford-college/

Medical History

Are you currently taking **prescription** medication(s)? ☐ Yes ☐ No

IF YES, please list all medications:

____
____
____
____

Please list **over the counter** (non-prescription) medications:

____
____
____

Do you have allergies?

☐ Yes ☐ No ☐ Not Sure

IF YES, check and list specific allergies:

☐ Medicine:

☐ Food:

☐ do you carry an epi pen? Y_________ N_____________ Do you need a refill?

Check if you have had any of the following:

☐ Diabetes	☐ Irregular Heart Rhythms	☐ Urinary Problems
☐ Blood Clots		☐ GYN Problems

☐ Seizures/ Epilepsy ☐ Mental/ Emotional Disease ☐ Retinal or Visual Changes ☐ Heart Problems	☐ Asthma or Respiratory Problems ☐ Hepatitis/ Liver Disorders ☐ Kidney Disease ☐ Stomach or Bowel Conditions	☐ Skin Disorders ☐ Varicella Disease (Chicken Pox) ☐ Other:

Have you had a PPD or Quantiferon gold blood test? ☐ Yes ☐ No ☐ Not Sure

What date did you have the PPD or Quantiferon gold blood test? ____________________

Did you ever have a **positive** PPD read or Quantiferon gold blood test? ☐ Yes ☐ No ☐ Not Sure

IF YES, how were you medically treated?

☐ Received the BCG vaccine?

☐ Received treatment for the positive PPD (ie. INH or Chest XRAY)

Any recent hospitalizations or surgeries? ☐ Yes ☐ No

IF YES, what date and which procedures?

Are you receiving any specialty care (i.e. psychotherapy, physical therapy)? ☐ Yes ☐ No

IF YES, please list specialties:

Please Complete

I ____________________________________ hereby verify that all the information I have filled out about my medical condition and history is correct and true to my knowledge.

Student Signature　　　　Date

Clinician　　　　Date

Please bring all documentation of prior immunizations and any pertinent medical information.