CALVIN COLLEGE OFF-CAMPUS PROGRAMS HEALTH INFORMATION

COMPLETE THIS FORM AND GIVE TO THE DIRECTOR OF YOUR OFF-CAMPUS SEMESTER OR INTERIM

Full name (Last) ____________________________(First) _____________________Date of birth__/__/__Calvin ID_____________
Calvin Address ____________________________(City)___________________(State)_______________________(Zip)_____________
Local Phone ___________________Cell Phone_________________E-mail Address ___________________________
Country Destination ________________________Director ____

The following directors should send these health forms, with a roster of participants, to Health Services in preparation for travel visit: 1) Semester program directors for China, Ghana, Honduras, Hungary, Peru, and Thailand, and 2) Interim program directors for Africa, Asia (except for Japan), Caribbean, Central America, Eastern Europe (except for Greece), Mexico, Pacific Islands (except for Australia and New Zealand), and South America. Program directors traveling to all other locations should collect these health forms from participants, take the forms with them on their programs, and shred them when the course is completed.

IN CASE OF EMERGENCY:

Emergency contact_________________ Relationship_________ Phone (Home) _________________ (Cell) ___________
Address (Street)________________________(City)__________________(State)___________(Zip) _______ (E-mail) ______________________
Physician name _________________________City____________________ Phone # __________________________
Insurance carrier ___________________________ Policy # __________________Group # _________________________

Allergies: drug, food, animal or sting: (type of reaction) ____

Check if you have any history of the following (explain below):

___ Asthma
___ Diabetes
___ Digestive problems
___ Ear/eye problems
___ Emotional/psychological difficulties
___ Fractures
___ Heart murmur
___ High or low blood pressure
___ Kidney/bladder problems
___ Liver problems
___ Seizures/epilepsy
___ Thyroid disorder
___ other

Explanation:____
____
____

Major illnesses, hospitalizations, and surgeries (give dates): ____
____

Current prescription and over the counter medications (name, dose, frequency):_________________________________
____
____

I attest that the above information is accurate and complete. By providing the emergency contact above, I am giving permission for that person to be contacted in case of an emergency. I give permission for the director of my program to discuss with Health Services and the Off-Campus Programs director any health issues that may affect my participation in this course, or my health while abroad. I understand that I will receive any vaccinations required for my trip, or will forfeit the right to participate in the trip.

Student Signature ____ Date ___________________

DO NOT WRITE BELOW THIS LINE---

Travel Health Comments: ____
____

Travel Health nurse signature____ Date__________________