

BOSIA STUDENT MEDICAL CLEARANCE

STUDENT NAME _____ **DOB** _____

HEALTH HISTORY: Page 1 must be completed by parent or guardian before the student's medical exam.

The information provided is confidential and will be used to assure that we are aware of your student's physical and mental health needs during the trip.

HOUSEHOLD #1			HOUSEHOLD #2		
Parents/Guardians:			Parents/Guardians:		
Address:			Address:		
City/State/Zip:			City/State/Zip:		
Home Phone:			Home Phone:		
Work Phone(s):			Work Phone(s):		
Cell Phone(s):			Cell Phone(s):		
E-mail(s):			E-mail(s):		

ALTERNATE EMERGENCY CONTACT

Name _____ Relationship _____
 Phone number _____ Cell Number _____

MEDICAL INSURANCE

Company Name _____ Policy number _____
 Subscriber _____ Group number _____

TRAVEL/INTERNATIONAL INSURANCE Y N If yes, please provide copy.

If Yes: Company name _____ Policy Number _____

HAS STUDENT HAD DISEASES/CONDITIONS LISTED BELOW

	YES	NO		YES	NO
ALLERGIES (drugs, foods, insects)	<input type="checkbox"/>	<input type="checkbox"/>	SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
HOSPITALIZATION	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
CHRONIC HEALTH PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
DISABILITY OR SPECIAL NEEDS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL HEALTH ISSUES	<input type="checkbox"/>	<input type="checkbox"/>	EATING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please describe in detail and indicate severity. Please share any additional information about your student's physical and mental health that might help the chaperones support your student during travel.

MEDICATIONS LIST ALL PRESCRIPTION AND NON PRESCRIPTION MEDICATIONS, DIETARY SUPPLEMENTS, VITAMINS AND HERBAL MEDICATIONS

Medication _____ Dosage _____
 Medication _____ Dosage _____
 Medication _____ Dosage _____
 Medication _____ Dosage _____

VACCINE HISTORY PLEASE SPECIFY MOST RECENT DATE (MONTH AND YEAR)

DTP/Tdap/Td _____/_____/_____ Polio _____/_____/_____ Meningitis _____/_____/_____
 MMR #1 _____/_____/_____ #2 _____/_____/_____ Varicella #1 _____/_____/_____ #2 _____/_____/_____ Typhoid _____/_____/_____
 HepA #1 _____/_____/_____ #2 _____/_____/_____ Hep B #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____

Your signature below attests that the information provided above is complete and that inaccurate or incomplete information could be harmful to your student's health.

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

BOSIA STUDENT HEALTH CERTIFICATE

STUDENT NAME _____ DOB _____

HEALTH CERTIFICATE: Page 2 must be completed and signed by the student's primary care provider. The primary care provider should not be related to the student. A physical exam must have occurred within 12 months prior to the date of travel.

Date of Last Exam _____

1. Height _____ Weight _____ B/P _____ Pulse _____

Please note any pertinent abnormalities on exam. _____

2. Has the student ever shown evidence of, or been evaluated or treated for a nervous, emotional, drug/alcohol or eating problem? Yes [] No []

3. Is there present evidence of an emotional, nervous, drug/alcohol or eating problem? Yes [] No []

If yes to either 2 or 3 above, a full report in a sealed envelope should be attached. Please note that if a student is experiencing current emotional, physical, personal or family difficulties, these difficulties can be exacerbated by the adjustment demands of the program. Therefore you are requested to evaluate carefully the student's current or previous condition along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

4. Are there any health limitations on the student's activities or any medical information that should be considered? Yes [] No []

If yes please describe: _____

5. Malaria medication is recommended for this student YES [] NO []

If yes name _____

6. I have approved the use by the student of the medications listed on page one Yes [] No []

Please prescribe Epi-Pen for this student if ANY history or concern for allergic reactions
Please prescribe an Albuterol MDI if ANY history or concern of asthma.
Please consider Tamiflu for this student if ANY history of asthma or other risk factors

7. I have reviewed the list of first aid medication protocols to be followed by the delegation's chaperones and approve their use for this student as needed. Yes [] No []

Note any exceptions: _____

I, the undersigned, certify that a thorough physical examination of the student has been given and all important recent medical information has been included on the health history and health certificate, that nothing relevant has been omitted and that the student is able to travel.

Primary Care Provider Name and Degree _____

Signature _____

Address and Phone Number _____

Date _____