

Houghton College  
Off-Campus Studies Office  
Health Information Form

Only needed for participants in **Houghton Honors and Highlander Wilderness Adventure**  
Please return to:  
Student Health Services  
Houghton College  
One Willard Avenue  
Houghton, NY 14744

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M or  F

Program:  Houghton Honors (Circle One): **London // East Meets West // Science**  Highlander Wilderness Adventure

**Deadline: July 31**

**Deadline: June 30**

<b>HEALTH HISTORY:</b>		<i>NOTE: Withholding medical information could result in dismissal from the program</i>		
<b>PAST MEDICAL HISTORY:</b>	Yes	No	If "yes," please give details here... (add a page if needed)	
Do you have any ongoing/ <b>chronic medical conditions</b> ?				
Have you ever had <b>surgery</b> ?				
Have you ever been treated for <b>emotional or mental health problems</b> ?				
Do you have any current physical limitations or mental health concerns?				
Do you take any <b>prescription medications</b> ? (If so, please list...)				
Do you take any <b>OTC meds/supplements</b> regularly? (If so, please list...)				
Do you have any <b>dietary restrictions</b> or preferences?				
Is there anything else in your medical history that would be important for program personnel to know?				
Please list your blood type, if known.				
<b>ALLERGIES:</b>	Yes	No	If "yes," please give details here...	
Do you have any allergies to <b>medications</b> ?				
Do you have any allergies to <b>insects/insect stings</b> ?				
Do you have any <b>food</b> allergies?				
Do you have any <b>environmental</b> allergies?				
<b>Note:</b> If you have severe allergic reactions you must carry your own medication for emergencies.				
<b>IMMUNIZATIONS: Please provide dates for the following.</b>		<i>NOTE: Check with your physician to be sure all your routine immunizations are up to date.</i>		
<b>REQUIRED FOR ALL PROGRAMS:</b>				
MMR (2 doses)				
Td/Tdap (within 10 years of program end)				
<b>REQUIRED FOR EAST AFRICA, SIERRA LEONE and other underdeveloped areas</b>				
Td/Tdap ( <b>within 5 years</b> of program end)				
Typhoid (either oral or injectable)				
<b>REQUIRED FOR SIERRA LEONE and may be needed for other areas*</b>				
Yellow Fever				
<b>HIGHLY RECOMMENDED FOR ALL:</b>				
Hepatitis A (at least one dose given at least 4 weeks before trip)				
Hepatitis B series				
<b>Contact Cattaraugus County Dept. of Health, Overseas Travel Clinic (716-373-8050) for immunization options, or consult your physician.</b>				
<b>Please alert the program director immediately and in person if you have a religious exemption for immunizations.</b>				
<b>MALARIA PROPHYLAXIS: (Medications taken while travelling to prevent malaria.)</b>				
<b>REQUIRED FOR EAST AFRICA*: Preferred medicine is doxycycline 100mg daily; Bring 3 months' supply with you.</b>				
<b>HIGHLY RECOMMENDED FOR SIERRA LEONE and may be needed for other areas**</b>				
*See program packet for important must-do details.				
<b>**Visit the Center for Disease Control website <a href="https://wwwnc.cdc.gov/travel/destinations/list/">https://wwwnc.cdc.gov/travel/destinations/list/</a> for destination-specific travel health guidance.</b>				
<b>PHYSICIAN'S ATTESTATION: Only required for full semester programs</b>				<b>Not applicable <input type="checkbox"/></b>
I have evaluated this student and reviewed the above information, which is accurate and complete to the best of my knowledge.				
I believe the student to be physically and emotionally fit to participate in the program indicated above.				
<input type="checkbox"/> I have attached recommendations if this box is checked.				
<input type="checkbox"/> (For EAST AFRICA) I have reviewed this student's current medications and verify that there are no significant interactions with doxycycline.				
_____	_____	_____		
Print Name	Signature	Date	<b>Page 1 of 2 (OVER)</b>	

**RATIONALE and PROCESS:**

Because of the stresses of overseas travel and potential health risks associated with participation in off-campus studies, it is vital for our directors to have access to the information collected on this form as they strive to protect the health and safety of the individual as well as that of other members of the group. This form will be reviewed by the director as well as by the staff of the Houghton College Health Center. Upon review, should it be determined that your health cannot withstand the rigors of the off-campus opportunity of choice, your acceptance may be rescinded. The form will be retained by the director and/or OCS office for reference during the program.

**Non-Houghton students** are required to authorize their school's health center to forward their Confidential Medical Report and Immunization Record to: Houghton College Health Center, Houghton College, Houghton, NY 14744.

**PRIVACY RELEASE: You must sign indicating agreement to the following:**

The preceding information is correct to the best of my knowledge. Further, I understand that withholding medical information could result in my dismissal from the program, and authorize members of the health center staff to share with the OCS office any additional medical or mental health information from my health center record that they feel would be important for program personnel to know. In addition, I am willing to submit to on-site regulations regarding health practices, preventive or emergency medications. I am willing to be treated by local health officials and am willing for others to decide on the need for medical evacuation in the event of an emergency. I give my permission for any and all personal information to be shared with any of the above people.

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

Parent/Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_  
*(required if participant is under 18 years old)*

**INSURANCE INFORMATION: Please provide the following insurance information...**

Family Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Relation to you \_\_\_\_\_  
 Subscriber ID # \_\_\_\_\_ Insurance Group Number \_\_\_\_\_

NOTE: Your primary insurance while abroad is still your family or coverage required by Houghton College. In addition you are covered by the ISIC foreign travel insurance plan (see flyer) and will be issued an ID card. In the event of needing medical treatment, you will most likely need to pay up front. Keep receipts to submit first, to your primary coverage, and then submit claims to the ISIC plan. The exception would be medical evacuation.

**EMERGENCY CONTACT INFORMATION: Please provide information for two individuals who can serve as emergency contacts...****FIRST CONTACT:**

Name: \_\_\_\_\_ Relation to you \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Primary phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_ Email: \_\_\_\_\_

**SECONDARY CONTACT:**

Name: \_\_\_\_\_ Relation to you \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Primary phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_ Email: \_\_\_\_\_

**HEALTH CENTER REVIEW: FOR OFFICE USE ONLY**

Comments:

Staff Initials: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_