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 // Science** ☐ Highlander Wilderness Adventure ☐ East Africa

Deadline: July 31 ***Deadline: July 31*** ***Deadline: July 31***

HEALTH HISTORY: ***NOTE: Withholding medical information could result in dismissal from the program***

PAST MEDICAL HISTORY:	Yes	No	If "yes," please give details here… (add a page if needed)
Do you have any ongoing/**chronic medical conditions**?			
Have you ever had s**urgery**?			
Have you ever been treated for **emotional or mental health problems**?			
Do you have any current physical limitations or mental health concerns?			
Do you take any **prescription medications**? (If so, please list…)			
Do you take any **OTC meds/supplements** regularly? (If so, please list…)			
Do you have any **dietary restrictions** 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.			

ALLERGIES:	Yes	No	If "yes," please give details here…
Do you have any allergies to **medications**?			
Do you have any allergies to **insects/insect stings**?			
Do you have any **food** allergies?			
Do you have any **environmental** allergies?			

Note: If you have severe allergic reactions you must carry your own medication for emergencies.

IMMUNIZATIONS: Please provide dates for the following. ***NOTE: Check with your physician to be sure all your routine immunizations are up to date.***

REQUIRED FOR ***ALL*** PROGRAMS:			
MMR (2 doses)			
Td/Tdap (within 10 years of program end)			
COVID-19			
OTHERS as noted:			
Td/Tdap (***REQUIRED*** **within 5 years** of program end for all underdeveloped countries)			
Typhoid (***REQUIRED*** East Africa [either oral or injectable])			
Yellow Fever (***REQUIRED*** for Sierra Leone and others)			
Hepatitis A (***HIGHLY RECOMMENDED*** for ALL) (at least one dose given at least 4 weeks before trip)			
Hepatitis B series (**Highly Recommended** for ALL)			

Contact Cattaraugus County Dept. of Health, Overseas Travel Clinic (716-373-8050) for immunization options, or consult your physician.

Please alert the program director immediately and in person if you have a religious exemption for immunizations.

MALARIA PROPHYLAXIS: (Medications taken while travelling to prevent malaria.)

REQUIRED FOR EAST AFRICA*: **Preferred medicine is doxycycline 100mg daily**; Bring 3 months' supply with you.

HIGHLY RECCOMENDED FOR SIERRA LEONE and may be needed for other areas**

*See program packet for important must-do details.

****Visit the Center for Disease Control website** https://wwwnc.cdc.gov/travel/destinations/list/ **for destination-specific travel health guidance.**

PHYSICIAN'S ATTESTATION: Only required for full semester programs **Not applicable** ☐

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.
☐ I have attached recommendations if this box is checked.
☐ (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

(OVER)

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 ha 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 t Houghton College Health Center, Houghton College, Houghton, NY 14744.

PRIVACY RELEASE: Your signature below indicates 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: _________________