



**STUDENT CHECKLIST AND REQUIREMENTS**

If you do not comply with all aspects of the pre-departure health evaluation, you may not be approved to participate in, or may be dismissed from, a study abroad program. UNM must receive accurate information about your physical and mental health. All information is confidential and shared only on a need-to-know basis with staff who will facilitate healthcare, particularly during an emergency, while you are abroad.

**CHECKLIST**

1. **COMPLETE** the Pre-Travel Health Questionnaire *ideally no later than 6-8 weeks before departure*.
2. **MAKE** a Pre-Travel Appointment/Consultation with your primary care provider (PCP). If you will be seeing UNM Student Health & Counseling (SHAC), this questionnaire must be completed online.
3. **FILL OUT** the Pre-Travel Health Questionnaire **completely and honestly**, make a copy, and submit it to your PCP together with your immunization records **before** your appointment. These documents must be reviewed by your PCP **before** your appointment. A copy of the Healthcare Provider Instructions should be provided.
4. **DISCUSS** your health history candidly at your appointment, even if you do not think that a condition might cause a problem for you while abroad. Full disclosure allows your PCP to help you protect your health!
5. **OBTAIN** a completed and signed Certificate of Health for Study Abroad **and timely complete** any required follow-up.
6. **SUBMIT** the completed and signed Certificate of Health and any attachments to your study abroad Program Leader.
7. **KEEP** the original Pre-Travel Health Questionnaire with your passport in case of a medical emergency.
8. **TAKE** a copy of the Pre-Travel Health Questionnaire abroad in case of a medical emergency.
9. **MAKE** additional copies of the Pre-Travel Health Questionnaire as needed. You may choose to give a copy to a healthcare provider abroad and/or to your study abroad Program Leader to use in case of a medical emergency.

**REQUIREMENTS**

**Students with known, chronic medical conditions** must take precautions to manage their condition. You must anticipate how the new environment and the stresses of study abroad can affect your health. Pre-existing psychological health conditions can be intensified by living in a different culture. There may be fewer resources to help you manage potential triggers than there are at UNM.

**Students on Medication Should Read the Following:**

1. **Taking Medication Abroad:** Customs officials may scrutinize prescription and non-prescription medication, so carry it in original containers. Medications that are legal and available in the U.S. may be illegal, or require a prescription or government permission to enter the host country. **You are responsible** for finding out if your medication is available and legal at your destination. See #2 below. If your regular medication (e.g., asthma inhalers, oral contraceptives) is legal, take a supply to last your entire stay with your physician's written explanation (on letterhead) of the medical necessity and treatment.
2. **Mailing Medication Abroad:** The host country government determines what medications may be mailed legally from the U.S. To avoid having your mailed refills of U.S. medications stopped by host country Customs officials, **you are responsible** for e-mailing or calling the host country's embassy or nearest consulate in the U.S. to find out if your medication is legal and can be mailed abroad without being detained, delayed, or fined by Customs officials. Alternatively, if you buy HTH Worldwide health insurance ([hthstudents.com](http://hthstudents.com) or [hthworldwide.com](http://hthworldwide.com)) **you are responsible** for calling 1-888-234-2358 (24/7) to make this very important inquiry. The HTH ID card provides important information about accessing healthcare while abroad.
3. If you are taking medication for a psychological or other medical condition, you must be medically stable with your medication before starting your study abroad program. **Medically stable means** that changes in symptoms are not foreseen or expected. Discuss proper medication management with your physician.
4. If you are being treated for a psychological condition, consult your healthcare provider to understand possible triggers, any medications you are taking, their availability abroad, and how to get help if needed while abroad. If deemed necessary by your provider, you must have a treatment plan identifying a therapist abroad and frequency of appointments. See HTH ID card info in #2 above.

## UNM-Sponsored Trips/Study Abroad Programs Pre-Travel Health Questionnaire & Certificate of Health

### HEALTHCARE PROVIDER INSTRUCTIONS

**\*\* READ carefully before signing form \*\***

Healthcare provider should not be student's immediate family member (AMA Code of Medical Ethics, Opinion 8.19)

- The student being evaluated cannot participate in his/her study abroad program unless the Pre-Travel Health Questionnaire & Certificate of Health are satisfactorily completed as instructed.
- Attention Specialists: If you are now seeing the student for a condition that may restrict or prevent participation in a study abroad program, you must also review and complete Pre-Travel Health Questionnaire & Certificate of Health.
- Physical examinations are not needed unless required by a particular study abroad program or host country. It is the student's responsibility to inform you of this requirement and to give you any pertinent forms and/or documents.

### PLEASE FOLLOW THESE STEPS:

1. Review the student's Pre-Travel Health Questionnaire & Certificate of Health for completeness and accuracy to avoid delays and/or rescheduling.
2. Discuss/review the student's health history thoroughly, referring to the Pre-Travel Health Questionnaire & Certificate of Health and the student's medical records on file, paying particular attention to necessary medications and immunizations, allergies, and active health problems. UNM is concerned for the well-being of students with on-going health conditions of any nature that will require medication and/or continued therapy while abroad.
3. List any physical, emotional, psychological, or learning disabilities or conditions the student may have so that UNM can help the student determine the availability of adequate services abroad.
4. Consider the student's fitness, medical history, and mental health in relation to the type of study abroad program and the destination country(ies) and expected living conditions to the extent you may be familiar with them (e.g., sanitation levels, proximity to Western-style health facilities and psychological services). Students must be able to adapt to changes in climate, diet, and living and studying conditions.
5. Complete and sign the Pre-Travel Health Questionnaire & Certificate of Health (original to student; copy for your records).

**THANK YOU VERY MUCH FOR YOUR ASSISTANCE!**

## Pre-Travel Health Questionnaire

A health evaluation ideally should be completed 8 weeks before departure. IF YOU DO NOT COMPLETE THE EVALUATION AS REQUIRED BY YOUR PROGRAM LEADER, YOU MAY NOT BE APPROVED TO PARTICIPATE IN, OR MAY BE DISMISSED FROM, a UNM study abroad program. This form and a review of your medical record on file will be used during the health evaluation. *UNM Student Health & Counseling (SHAC) or your primary healthcare provider must be informed of any recent medical or special needs or changes in health that occur before the start of the program. Failure to provide complete and accurate information may be grounds for non-participation in a study abroad program. If you receive a Certificate of Health for Study Abroad before a change in health occurs that may restrict or prevent your participation, you must return to the examining provider for further evaluation.*

**Fill in this form COMPLETELY AND ACCURATELY BEFORE your medical appointment.** Failure to disclose health problems may have serious medical consequences while abroad.

**PRINT:** \_\_\_\_\_ Sex: M ☐ F ☐  
 Last name First Middle Country of Origin  
 Program/Country \_\_\_\_\_ Student I.D. # \_\_\_\_\_

Emergency contact person's name, city, state, area code/best phone number, and e-mail address (IMPORTANT: Please print legibly!)

### GENERAL HEALTH:

Are you currently under the care of a doctor or other healthcare provider, including care for psychological conditions? Yes ☐ No ☐ If so, fill in the following:

Provider's Name: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

Address: \_\_\_\_\_

For what condition(s): \_\_\_\_\_

List any recent or continuing health problems: \_\_\_\_\_

List any physical or learning disabilities: \_\_\_\_\_ Do you smoke? Yes ☐ No ☐

### SURGICAL HISTORY: List year

### MEDICAL HISTORY: Complete below.

	Y	N	Date		Y	N	Date		Y	N	Date
Headaches				Ulcer/colitis				Back/joint problems			
Epilepsy/seizures				Hepatitis/gallbladder				High blood pressure			
Asthma/lung disease				Bladder/kidney problems				Thyroid problems			
Heart disease				Diabetes				Recurrent or chronic infectious diseases			
Anemia or bleeding disorder				Cancer/tumors				Splenectomy			
Psoriasis				Thymectomy				Other (List) _____			
Autoimmune Disorder											

### MENTAL HEALTH HISTORY: Have you ever suffered from, or been treated or hospitalized for the following?

	Y	N	Please explain any "Yes" answers.
Any mental health condition, such as depression/anxiety			
Substance abuse (alcohol or drugs)			
Eating disorder (anorexia/bulimia)			
Are you taking/have ever taken medication for above problems?			

**MEDICATIONS:** List all prescription and non-prescription medications you currently use, including any you routinely carry, e.g., inhaler, bee sting kit, etc.

**DRUG/FOOD ALLERGIES:** List and briefly describe reaction: \_\_\_\_\_

**FACILITATIVE SERVICES NEEDED** (e.g., note takers): \_\_\_\_\_

*I certify that all my responses on this form are complete, true, and accurate. I understand that if there are any changes in my health, I will contact SHAC or my primary healthcare provider immediately. I understand that if I withhold information from this form I may be withdrawn from my study abroad program.*

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Keep **ORIGINAL** with your passport in case of emergency. **Give a copy** of completed form to examining healthcare professional. You may choose to give a copy to a healthcare provider abroad and your Program Leader to use in case of emergency.

## UNM-Sponsored Trips/Study Abroad Programs Pre-Travel Questionnaire page 2

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Date(s) of departure: From Albuquerque \_\_\_\_\_ From the U.S. \_\_\_\_\_  
 Date(s) of return: To the U.S. \_\_\_\_\_ To Albuquerque \_\_\_\_\_  
 List all destination countries and dates in each: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### ACTIVITIES WHILE TRAVELING (check all that apply):

☐ Undergraduate faculty-led study abroad program      ☐ Graduate or professional faculty-led study abroad program  
☐ Nurse, physician, or other allied health personnel      ☐ Missionary      ☐ Animal handler      ☐ Water activities  
☐ Anthropologist      ☐ Spelunker      ☐ High altitude trekking      ☐ Cycling/motor bike  
☐ Archaeologist      ☐ Biologist      ☐ Veterinarian      ☐ OTHER \_\_\_\_\_

### IMMUNIZATION SCHEDULE (medical staff use only)

### RECOMMENDATIONS:

Immunizations	Check if advised	Date	Date	Date	Declined (patient's initials)	Anti-Malarial	Strength	Amount										
Diphtheria-Tetanus (DT or Td) Tdap						1. Lariam	250 mg											
Hepatitis A Titer <input type="checkbox"/>						2. Aralen	500 mg											
Hepatitis B Titer <input type="checkbox"/>						3. Malarone	250 mg/100 mg											
Twinrix						4. Doxycycline	100 mg											
Influenza						<b>Medications</b> <input type="checkbox"/> Ciprofloxacin 500 mg  <input type="checkbox"/> Rifaximin 200 mg  <input type="checkbox"/> Zithromycin												
Measles (Monovalent)																		
Measles, Mumps & Rubella (MMR)																		
Polio: Oral (OPV)		Completed:																
Polio: Injectable (IPV)						<b>Review/Discussed/Handouts</b>												
PPD Pre-Travel																		
PPD Post-Travel																		
Varicella Vaccine																		
Hx Dz _____ Titer						<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Travelers' Diarrhea</td> <td style="width: 30%;"></td> </tr> <tr> <td>Insect Protection</td> <td></td> </tr> <tr> <td>Gen Travel Info/Safety</td> <td></td> </tr> <tr> <td>Travelers' Insurance</td> <td></td> </tr> <tr> <td>ETOH/Drugs</td> <td></td> </tr> </table>			Travelers' Diarrhea		Insect Protection		Gen Travel Info/Safety		Travelers' Insurance		ETOH/Drugs	
Travelers' Diarrhea																		
Insect Protection																		
Gen Travel Info/Safety																		
Travelers' Insurance																		
ETOH/Drugs																		
Typhoid Inject																		
Typhoid Oral																		
Rabies Discussed _____ Titer																		
Meningococcal																		
Japanese Encephalitis																		
Yellow Fever																		
Pneumococcal																		

### Student to initial all that apply:

☐ I've been informed about & have reviewed the required &/or recommended immunizations/medications as well as travel risks & safety prevention.  
☐ I acknowledge that I have refused the above indicated vaccines &/or medications.  
☐ I acknowledge that I may not have enough time to get optimal immunity from all of the immunizations I am receiving, and I am aware of the risks.

### Practitioner comments:

Student's Signature and Date \_\_\_\_\_

Practitioner's Signature and Date \_\_\_\_\_  
 X:\Handouts\Patient Handouts\Travel Health\  
 UNM Trips Questionnaire.pdf - Form revised 3/27/15

Undersigned healthcare provider should not be patient's immediate family member (AMA Code of Medical Ethics, Op. 8.19).

**The University of New Mexico  
Student Health and Counseling**

MSC 06 3870

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Albuquerque, New Mexico 87131

505-277-3136

**CERTIFICATE OF HEALTH  
FOR UNM-SPONSORED TRIPS/STUDY ABROAD**

\_\_\_\_\_  
Printed name & dates of study-abroad program

\_\_\_\_\_  
Patient's printed name and UNM ID number

\_\_\_\_\_  
Patient's emergency contact person's name, city, state, area code/best phone number, and e-mail address (Patient: please print legibly)

I, the undersigned health care provider, have reviewed the patient's Confidential Health History Form, and any medical records on file, with the patient. Based on the information provided to me by the patient on the Confidential Health History Form, and following a review of the Form and discussion with the patient of his/her health history, to the best of my knowledge:

1. \_\_\_\_ The patient has no current medical problem that restricts or prevents participation in the study-abroad trip pertinent to this Certificate (the "Program").
2. \_\_\_\_ The patient has a current medical problem, but it is not expected to restrict or prevent participation in the Program if the patient manages it as advised below. Medical problems and concerns were addressed, and patient was educated on the use of any medication needed to control on-going medical condition(s) during the Program.
  - a \_\_\_\_ Patient instructed to arrange services to facilitate education (e.g., note-taking, wheelchair access). **Patient must request a letter** from UNM Disability Services to the Program Leader documenting disability and indicating who will pay for services.
  - b \_\_\_\_ Patient instructed to arrange services to facilitate a healthy and safe stay abroad. Patient advised to meet before the Program with prescribing provider if on medication or with therapist if under care (if other than undersigned).
  - c \_\_\_\_ Patient instructed to find out if his/her medication is legal and available abroad, or if there is an appropriate substitute. If legal but not locally available, patient advised to arrange for or to take a sufficient supply to last throughout the Program.
3. a \_\_\_\_ The patient has a current medical problem that may restrict or prevent participation in the Program. Based on medical history, patient instructed to consult with an appropriate medical and/or mental healthcare provider for further evaluation to determine fitness for participation in the Program. **Patient must request a letter** from the consulting medical and/or mental healthcare provider(s) to the study abroad Program Leader indicating whether or not the medical problem restricts or prevents participation.

It is understood that your primary health care provider or the specialist seen must be informed of any changes in health that occur after obtaining the CERTIFICATE OF HEALTH and, if needed, must return for further evaluation.

Licensed Physician/Health Care Provider, MD, PA, NP, DO

\_\_\_\_\_  
Area code, phone number, and e-mail address

\_\_\_\_\_  
Signature and Date

\_\_\_\_\_  
Typed/printed name and license

\_\_\_\_\_  
Mailing address

By signing below patient acknowledges receipt of this certificate.

\_\_\_\_\_  
Signature and Date