

WELLESLEY COLLEGE PRE-TRAVEL SCREENING FORM

NAME:

PROGRAM SPECIFIC FORM?

YES

NO

DOB:

Year of Graduation:

Telephone:

Please complete the following information to help us individualize travel advice for your trip; including, but not limited to, vaccine administration, anti-malarial medication and travelers diarrhea.

Country of Birth:	Reason for travel:	
	<input type="checkbox"/> Wellesley College Program	<input type="checkbox"/> Vacation
	<input type="checkbox"/> Non-Wellesley College Program	<input type="checkbox"/> Volunteer

LIST COUNTRY(S) AND CITIES YOU WILL VISIT IN ORDER OF TRAVEL		DATES OF STAY:	Urban	Rural	Hotel	Dorm	Host Family
COUNTRY	CITIES	___/___/___ to ___/___/___					
		___/___/___ to ___/___/___					
		___/___/___ to ___/___/___					
		___/___/___ to ___/___/___					
		___/___/___ to ___/___/___					
		___/___/___ to ___/___/___					

Please list allergies below:

ALLERGIC TO:	YES	NO	TYPE OF REACTION
Bee sting			
Yeast			
Gelatin			
Latex			
Seasonal/Environmental			
Foods			
Medications			

Please list any MEDICATIONS (including oral contraceptive, Nuva Ring, IUD and non-prescription) you are currently taking:

Name	Dose	Times/Day	Reason for taking the medication

PLANNED ACTIVITIES:	YES	NO
High Altitude		
Scuba Diving		
Working with Children		
Working with Medical Staff		
Working with Animals		

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NAME:
DOB:
CLASS:

Please complete the following questions regarding CURRENT OR CHRONIC MEDICAL PROBLEMS:

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
1. Do you have a severe allergy or history of anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have G6PD deficiency ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you currently have HIV an immune system disorder, leukemia or cancer ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had your spleen removed ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have rheumatoid arthritis or lupus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a recent cancer diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you taking immunosuppressive medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples include: prednisone, TNF blockers, methimazole, methotrexate.			
Medications for HIV, Rheumatoid arthritis, Lupus, anti-cancer drugs or Radiation Therapy			
8. Have you ever had a seizure or epilepsy ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any gastrointestinal disorders ? (IBS, Celiac disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have irritable bowel disorder ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have significant dietary restrictions (allergy, celiac, other) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have cardiac disease, irregular heartbeat or high blood pressure ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have asthma ? (either active or intermittent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have kidney disease ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have an active gynecological concern ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you pregnant or desire to become pregnant in the next 3 months ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you currently breastfeeding ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have frequent urinary tract infections ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you currently being treated for or have a history of anxiety ? (within the past 2 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you currently being treated for or have a history of depression ? (within the past 2 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Are you currently being treated for or have a history of bipolar disorder ? (within the past 2 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Are you currently being treated for or have a history of schizophrenia ? (within the past 2 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had a bleeding disorder ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you require special testing or follow up while you are away?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Example: HIV, any other long term medical illness.

** STUDY ABROAD STUDENTS ONLY (not CWS, faculty lead trips, travel not involved with Office of International Studies)

**If you have identified a mental health concern, please request documentation from a mental health professional re: your readiness to study abroad. Please have this professional identify what services/supports might be required on-site if a concern was to arise while abroad. If you do not have a current therapist, please contact the Stone Center (781-283-2839) to have a mandatory evaluation. Submit this outside documentation to the Stone Center Director.

SIGNATURE OF TRAVELER COMPLETING FORM: _____

PRINT NAME: _____

REVIEWED BY: _____ DATE: _____