

Medical Release and Medical History for Travel Experiences

This form must be completed and submitted to the Chaplain's office prior to departure on a travel experience

Personal Information

Name _____
Last First Middle Male or Female?
Address _____
Street or RFD City State Zip Code Telephone Number
Date of Birth _____
Social Security Number
Primary Medical Insurance _____
Carrier Policy Number Telephone Number
Secondary Medical Insurance _____
Carrier Policy Number Telephone Number
Name of Parent, Guardian or Spouse _____
Home Telephone Number
Address _____
Work Telephone Number

Medical Emergency Contact

Name _____
Home Telephone Number
Address _____
Work Telephone Number
Relationship: ___Parent ___Guardian ___Spouse ___Brother ___Sister ___Other _____

Each person participating in a Mount Vernon Nazarene University travel experience must complete this medical release, and have it notarized before departure. In the case of a legal dependent (i.e., claimed on parent or guardian's federal income tax return), the parent or legal guardian must complete, sign, and have the release notarized.

Note to Faculty Supervisors: The signed and notarized copies of the medical release must be carried with you during the travel. They should not be sent to the travel destination, since they may be required by the hospital or physician before medical assistance can be given.

Date: _____

I hereby give _____ (trip leader) or _____ (other team member) permission to secure immediate medical treatment for me in the event that I am not able to make that decision due to an injury or illness. In the case of a legal dependent, I, the legal guardian, give permission to the aforementioned to secure immediate medical treatment for my dependent in the event of accident or illness. In either case, it will be from the date of _____ to _____.

Name: _____

Signature: _____
(If legal dependent, guardian's signature)

(This portion below is to be completed by a Notary.)

State of _____

County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 200____.

Notary Public

Expiration Date

(Notary Seal)

(continued on reverse side)

Personal Medical History

Have you ever had, or have you now, any of the following? If "yes," give the details below.

Answer each item	yes	no	yes	no	yes	no	yes	no	
Asthma	yes	no	Heart trouble	yes	no	Migraine headaches	yes	no	
Convulsions	yes	no	High/low blood pressure	yes	no	Mononucleosis	yes	no	
Diabetes	yes	no	Kidney trouble	yes	no	Motion sickness	yes	no	
Dizziness/fainting spells	yes	no	Loss of limb or digit	yes	no	Muscle/bone/joint disease	yes	no	
Epilepsy	yes	no	Menstrual disorders	yes	no	Nervous/mental disorder	yes	no	
							Shortness of breath	yes	no
							Stomach/intestinal disorder	yes	no
							Swollen/painful joints	yes	no
							Thyroid condition	yes	no
							Wear corrective lenses	yes	no

If you answered "yes" to any of the above, or if you have other medical conditions, please give the details: _____

Are you allergic to any serum and/or medication? If so, give the serum and/or medication, and the nature of your reaction: _____

Are you allergic to any type of food? If so, give the food, and the nature of your reaction: _____

Do you regularly take any kind of over-the-counter or prescription medication? If so, give the name, dosage level, and frequency of use.

Please describe any psychiatric or psychological problems (e.g., anorexia, bulimia, claustrophobia, depression, panic attacks, phobias, suicide attempts, etc.) or any other medical condition and include dates and treatments. _____

Height _____ Weight _____

Please describe the type, nature, and frequency of your physical exercise routine. _____

Give the date of your last tetanus booster. _____

Give the date of your last hepatitis A immunization or booster. _____

Have you taken the series of 3 hepatitis B vaccinations? yes no If "yes", give dates. _____

Additional Health Needs

Answer each item	While on the travel trip will you need	yes	no	If "yes", please give details.
1. to take allergy shots?		yes	no	_____
2. to be seen by a physician regularly?		yes	no	_____
3. to be helped with physical mobility?		yes	no	_____
4. psychiatric consultation or therapy?		yes	no	_____
5. follow-up care for any existing injuries or illnesses?		yes	no	_____

Statement of Affirmation and Consent

By completing this form, and signing it below, I agree to each of the following.

- I affirm that the information provided on this form is accurate and complete. I understand that if I knowingly provide inaccurate or incomplete information (a) I release the University of any liability, and (b) I am subject to disciplinary action by University officials.
- I give my permission for the information on this form may be used by the University officials in an emergency situation.
- I give my permission for University officials to inform my designated "medical emergency contact" in an emergency situation.
- I have attached a copy of my health insurance card to this form.
- I have read any State Department reports pertaining to the nature of this trip and/or my travel itinerary in general.

Destination _____ Dates of Travel _____

Student Signature _____ Date _____

Legal Guardian Signature (if student is legal dependant) _____ Date _____