WELLESLEY COLLEGE PRE-TRAVEL SCREENING FORM

NAME: **CATEGORY 1 2 3**

DOB:

Telephone: **Year of Graduation:**

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:**	
	☐ Wellesley College Program	☐ Vacation
Additional Health Form Required: ☐ Yes ☐ No	☐ Non-Wellesley College Program	☐ Volunteer

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

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 ____/____/____					

Please list allergies below:

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

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

Name	Dose	Times/Day	Reason for taking the medication

WELLESLEY COLLEGE PRE-TRAVEL SCREENING FORM

NAME:
DOB:
CLASS:

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

	Yes	No	Don't Know
1. Do you have a severe allergy or history of anaphylaxis?	☐	☐	☐
2. Do you have G6PD deficiency ?	☐	☐	☐
3. Do you currently have HIV an immune system disorder, leukemia or cancer ?	☐	☐	☐
4. Have you had your spleen removed ?	☐	☐	☐
5. Do you have rheumatoid arthritis or lupus?	☐	☐	☐
6. Do you have a recent cancer diagnosis?	☐	☐	☐
7. Are you taking immunosuppressive medication?	☐	☐	☐
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 ?	☐	☐	☐
9. Do you have any gastrointestinal disorders ?	☐	☐	☐
10. Do you have irritable bowel disorder ?	☐	☐	☐
11. Do you have significant dietary restrictions (allergy, celiac, other) ?	☐	☐	☐
12. Do you have cardiac disease, irregular heartbeat or high blood pressure ?	☐	☐	☐
13. Do you have asthma ?	☐	☐	☐
14. Do you have kidney disease ?	☐	☐	☐
15. Do you have an active gynecological concern ?	☐	☐	☐
16. Are you pregnant or desire to become pregnant in the next 3 months ?	☐	☐	☐
17. Are you currently breastfeeding ?	☐	☐	☐
18. Do you have frequent urinary tract infections ?	☐	☐	☐
19. Are you currently being treated for or have a history of anxiety ?	☐	☐	☐
20. Are you currently being treated for or have a history of depression ?	☐	☐	☐
21. Are you currently being treated for or have a history of bipolar disorder ?	☐	☐	☐
22. Are you currently being treated for or have a history of schizophrenia ?	☐	☐	☐
23. Have you ever had a bleeding disorder ?	☐	☐	☐
24. Do you require special testing or follow up while you are away?	☐	☐	☐
Example: HIV, long term medical illness.			

** If you have identified a mental healh concern, please request documentatin for a current therapist addressing your readiness to study abroad. Please have the therapist identify what services/supports might be required on-site if a concern was to arise whle abroad. If you do not have a current therapist, please contact the Stone Center (extension 2839) to have a mandatory evaluation. Submit documentation to OIS.

SIGNATURE OF TRAVELER COMPLETING FORM: _____

PRINT NAME: _____

REVIEWED BY: _____ **DATE:** _____