

Travel Health Questionnaire

This form is to be completed in its entirety by the student's parent or guardian

Student's Name: _____
last first middle

Date of Birth _____

Destination of Trip: _____

Medical Information – it is very important the adults who accompany your child on this trip are prepared for health issues that might arise when your child is away from home. Please include psychological as well as physical diagnoses. This information will be available only to the adults associated with this trip and shared only on a “need to know” basis.

Does your child have any medical problems? None Yes (If you checked “Yes” please explain below)

Does your child have any psychological or mental health issues? None Yes (If you checked “Yes” please explain below)

Is your child on any medications? None Yes (If you checked “Yes” please explain below)

Does your child have any allergies to medications, foods or insects? None Yes (If you checked “Yes” please explain below)

Does your child have an EpiPen? No Yes

Does your child have any dietary restrictions: None Yes (If you checked “Yes” please explain below)

Swimming Ability: non-swimmer/poor beginner intermediate advanced

Has your child received the Covid-19 vaccine? No Yes

If yes: Please list the name of the vaccine and date(s) of each dose: _____

Has your child received a typhoid vaccine in the past? No Yes

If yes: Was the vaccine oral or injectable

If yes, please list the date of vaccine: _____

Has your child received yellow fever vaccine in the past? No Yes

If yes, please list the date of vaccine: _____

Has your child received the Japanese encephalitis vaccine in the past?

No Yes

If yes, please list the date of vaccine: _____

By signing below, I, _____ [printed name of parent/guardian], attest that I have completed this form accurately and completely, and that I have read, understood, and have had the opportunity to ask questions about the Travel Medicine Advisory letter provided by the Health Center. I also understand that it is my responsibility to update the Health Center with any updates or changes to my child's medical condition between the completion of this form and the start of the trip.

Signature of parent
or guardian: _____

Date: _____

Permissions and Acknowledgements

The following permissions and acknowledgements are requested. The signature of a parent or guardian is required on this form prior to participation in classes and sporting activities. Every effort will be made to contact parents or guardian for serious illnesses, serious psychiatric concerns, serious injuries, operations or protracted or complex treatments. Medical information may be shared with both parents listed on this form unless separately documented and submitted.

I hereby grant permission to the school medical staff to provide medical care to my child during the years that he or she attends the above-mentioned school, as well as to submit claims to my insurance carrier for the care provided.

I hereby grant permission to the school counseling staff to provide counseling services as needed or requested by my child during the years he or she attends the above mentioned school. I have read the What is Counseling document on the parent portal. I acknowledge and agree to abide by this services protocol.

I hereby grant permission to the school Medical Director to represent me during the years that my child attends school with full power to authorize and consent to any medical treatment of my child in the event of a medical or surgical emergency, including hospitalization, anesthesia and surgery. This permission is in the event that I am unable to be contacted and medical or surgical judgment indicates that further delay would represent a risk to my child.

I hereby grant permission to the school Medical Director to represent me during the years that my child attends the school with full power to authorize and consent to any treatment for my child in an Emergency Room or medical office and to any labs or imaging exams, including but not limited to ultrasounds, X-rays, MRIs and CT scans.

I hereby acknowledge that I have received a Notice of Privacy Practices that describes how the Health Services of the above-mentioned school may use and disclose my child's health information. As noted in the Notice of Privacy Practices, medical information may be shared with the Head of School and her advisors to facilitate decisions concerning a Medical Leave pursuant to the Medical Leave Policy.

I hereby acknowledge that the above-mentioned school does not necessarily conduct or require the health examinations that my state may require for public school students. I understand I can consult with my health care provider, my local school committee or my local board of health to learn more about these exams and that if I want these exams carried out on my child, it will be my responsibility to do so.

Student Name: _____

Signature of Parent or Guardian: _____

Date: _____

Signature of Student if over 18 yo: _____

Date: _____