Wake Forest University
Health Questionnaire for Participation in International Travel

Full Name_____ Age_____ Sex___
Last First Middle
Birth Date_____ Marital Status_____
Home Address_____ Telephone(____)_____

Name and Relationship of next of kin_____
Address of next of kin_____
Telephone of next of kin(____)_____

Name, address, telephone of Family Physician_____
_____

HEALTH INSURANCE INFORMATION REQUIRED:
Will your current health insurance policy cover you in the country to which you are going?
_____Yes _____No*
***If your current health insurance policy does not provide coverage while you are abroad, you must purchase health insurance specifically for that purpose. Medical evacuation and repatriation coverage is recommended.**

***AUTHORIZATION AND CONSENT*:**

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person, and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluation and treat all other injuries or illnesses for which help is sought. In the case of a minor (under 18 years of age) this treatment may proceed without prior notification of the undersigned parent or guardian, although every attempt will be made to notify the parent or guardian in the event of such an injury or illness. I also agree that needed immunizations may be administered. I further agree that any medical information may be released to or by other health care providers who may be providing care or who are knowledgeable of my medical history.

Signature of Faculty/Staff/Student_____ Date_____

Signature of minor's (under 18) parent or guardian_____
Date_____

(continued)

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS.
Comment on all positive answers under remarks.

HAVE YOU HAD?	Yes
Allergy to:	
Penicillin	
Sulfonamides	
Peanuts	
Bees, wasps	
Other	
Specify:	
Infectious mononucleosis	
Tropical disease - specify	
Chicken pox/Varicella	
Respiratory disorders including asthma	
High blood pressure	
Diabetes, thyroid, endocrine problems	
Stomach or intestinal disorders	
Blood disorders including anemia	
Headaches/migraines	
Menstrual cycle disorders	
Current prescription medicines – list	
Current vitamins or supplements - list	

HAVE YOU HAD	Yes
Surgery or serious injury	
Chronic medical condition - specify	
Vision, corrective lens	
Cancer	
Heart disease	
Serious head injury	
Hepatitis B	
Hepatitis C	
Kidney disease	
Neurological disorder	
Depression/anxiety	
Other psychological problem	
Seizure disorder	
Organ loss	
Current non-prescription medicines - list	

REMARKS OR ADDITIONAL
INFORMATION:_____
_____
_____

Are you capable of participation in a full program of activities? _____Yes _____No
Is there anything additional about your health that we should know? _____Yes _____No
Are you now under treatment with medication for any medical or emotional condition?
_____Yes _____No
If "yes", please explain_____

Do you have a disability that may require an academic or another type of accommodation to enable you to participate in this program? _____Yes _____No
If yes, please contact Van D. Westervelt, PhD or Michael Shuman, MEd at the Learning Assistance Center, P.O. Box 7283 Reynolda Station, Winston-Salem, NC 27109, (336) 758-5929, to make your accommodation request.

Signed:_____Date:_____
Faculty/Staff/Student (Parent or Guardian)