OUWB Global Health Personal Health Checklist

This personal Health Checklist must be completed by each student who is traveling and the completed form should be returned to the OUWB Coordinator of Global Health. This document contains your personal information, is protected by confidentiality laws and will only be shared in the event of a medical emergency while you are abroad. You are advised to bring a copy of this document with you when you travel and to leave a copy with your emergency contact person in the USA.

I. Personal Information

Name:	
Date of Birth:	Age:
Passport	
Country:	Number:
Expiration:	
Home Address:	
Phone:	Cell Phone:
E-Mail:	

II. Emergency Information

List an emergency contact in the USA who will not be traveling with you

Name:					
Relationship:					
Parent ☐	Spouse ☐	Partner ☐	Child ☐	Sibling ☐	Other ☐
Phone:			Alternate Phone:		
E-Mail Address:					

Personal Physician (Who may be consulted on your health care in case of emergency)

Name;
Phone:
Specialty within medicine:

Travel and evacuation insurance information (All students who are traveling must have a health insurance plan that provides coverage when out of the country)

Carrier or plan name:	
Carrier address:	
Name of insured:	Insurance ID No:
Carrier phone No. (From overseas):	
Carrier phone No. (from USA):	

III. Personal Health Information

<table>
<tr><td colspan="2">Allergies (Describe reaction and management of the reaction. Attach additional sheets of needed)</td></tr>
<tr><td colspan="2">Medication allergies:</td></tr>
<tr><td>Name</td><td>Reaction</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Food allergies:</td><td></td></tr>
<tr><td colspan="2">Other allergies (inset stings, hay fever, plants, animals, dust, etc.):</td></tr>
<tr><td colspan="2">Reason:</td></tr>
</table>

Eyewear: If you wear glasses or contact lenses, make sure you have an extra pair and sufficient contact solution, etc. Contact lenses are often problematic due to weather conditions, dust, and poor sanitation. This can make it difficult to keep contact lenses clean and increases the risk of eye infections. Bring a good pair of sunglasses.

A. What is your blood type? _____

B. Have you had a recent injury, illness or infectious disease? Yes ☐ No ☐
Date: _____
If yes, please describe _____
_____

How was this treated? _____

C. Do you have any of the following?

	Yes	No	Treatment
Anemia			
Asthma			
Bi-polar disorder			
Closed head injury			
Crohns/Colitis			
Depression			
Diabetes			
Epilepsy			
Hypertension			
Hypotension			
Migraines			
Renal disease			
Seizure disorder			
Ulcers (peptic)			
Others (please list)			

D. Do you receive allergy shots? Yes ☐ No ☐
If so, will you be bringing the allergy extract with you? Yes ☐ No ☐

E. Frequency of allergy desensitization: Every _____ Week

F. Do you take any medications on a routine basis? Yes ☐ No ☐

Medications you are currently taking:
List all medications (including over-the-counter or non-prescription drugs) you take routinely or use in case of an emergency. Bring enough medication to last the entire trip. Keep all medications in the original packaging/bottle that identifies the prescribing physician, the name of the medication, dosage, frequency of administration.

Complete this medication list (include birth control and all things that are taken on an as needed basis as well e.g. Epinephrine for allergic reactions, asthma inhaler, etc.). Please add additional pages as needed.

INCLUDE MALARIA PROPHYLAXIS, IF PERSCRIBED

Med #1:	Dosage:	Frequency:
Reason:		
Med #2:	Dosage:	Frequency:
Reason:		
Med #3:	Dosage:	Frequency:
Reason:		
Med #4:	Dosage:	Frequency
Reason:		
Med #5:	Dosage:	Frequency
Reason:		

IV. List any other health issues or diagnosed condition that a health care provider should be aware of in an emergency. (Use additional pages if needed)

V. Screenings and Immunizations

A. Tuberculosis screening

(PPD test should be within 2 years prior to travel and repeated 3 months after return)

Most recent TB PPD Skin Test:	
Date:	Size (mm):
Result:	
If you had a positive PPD skin test in the past, provide the date of your most recent chest X-Ray and results:	
Date:	Result:
Have you ever been treated for latent TB infection? Yes ☐ No ☐	
If yes, Date: Treatment:	

B. Vaccinations (be sure to have your Yellow Vaccination record with you.

Use this page to provide additional information that may be needed in case of an emergency.