

TRAVEL HEALTH CONSULTATION INSTRUCTIONS



Missouri S&T students who study abroad must see a licensed healthcare provider to review their travel and health history. The information provided will not affect eligibility to study abroad but will be used to assist in managing health conditions while abroad. This may be completed at any time during the application process but best to be completed at least six weeks prior to travel.

STUDENT INSTRUCTIONS:

1. The Travel Health Consultation form may be completed by Missouri S&T Student Health Services or a health care provider of your choice. Fill out the Student Information section of this form and take the form with you to your appointment.
2. If you select Missouri S&T [Student Health Services](#) as your provider, please call for an appointment. You will then be given an online travel questionnaire to complete as soon as possible before your appointment. There is never any charge to be seen at Student Health Services. You may incur charges for vaccinations or medications needed for your travel.
3. This form is required by Missouri S&T study abroad and is in addition to any forms required by your program. Some programs may require a separate travel health consultation due to program requirements and/or country-specific risks.
4. You must ensure that this completed and signed Travel Health Consultation form is uploaded to your study abroad / travel registry portal.

HEALTH CARE PROVIDER GUIDELINES:

Students who wish to study abroad must be seen by a health care provider. Please include the following steps and considerations in your consultation:

1. Review and discuss the student's health history, paying particular attention to medications that the student may need to continue, any allergies the student may have, and all currently active health problems.
2. Assess the need for any continued health care including counseling, medication refills, or laboratory testing while abroad so the student can determine the availability of adequate facilities at the program site.
3. Review the Centers for Disease Control and Prevention (CDC) travelers' health website (www.cdc.gov/travel) for immunization requirements or other health related issues for the destination country and review these with the student. If certain travel vaccinations or medications are required/recommended for the destination that your clinic does not offer, please refer the student to Missouri S&T Student Health Services.



TRAVEL HEALTH CONSULTATION FORM

STUDENT INFORMATION:

| | | |
|---|-------------------------------------|--------------------------------|
| _____ | _____ | _____ |
| FIRST AND LAST NAME OF STUDENT | MISSOURI S&T ID# | TERM(S) ABROAD (e.g.FALL 2023) |
| _____ | _____ | |
| PROGRAM NAME (PROGRAM OR HOST UNIVERSITY) | LOCATION OF PROGRAM (CITY, COUNTRY) | |

I have read the student instructions and disclosed any known health history to the healthcare provider.

| | |
|-------------------|-------|
| _____ | _____ |
| STUDENT SIGNATURE | DATE |

TRAVEL CONSULTATION: Completed by the Health Care Provider

Health Care Provider must be licensed in the U.S. and cannot be an immediate family member (AMA Code of Ethics E-8-19).

1. See **Health Care Provider Guidelines** prior to completing this form.
2. After reviewing the student's health history and CDC's travelers' health information and performing an appropriate medical exam, review these with the student and discuss their ability to travel and live abroad and complete this section of the form.
3. Please list any recommendations for conditions that may require follow-up care while the student is abroad.
4. Make sure the student receives this signed form for their study abroad application.

RECOMMENDATIONS AND SIGNATURE

➤ Are there any medical or psychological condition(s) that currently affect this student and may require follow-up care while the student is abroad?

YES – Please explain: _____

NO

➤ Do you have any concerns about this student's physical fitness to participate in an international study program that may include a moderate amount of physical activity?

YES – Please explain: _____

NO

Licensed Health Care Provider

| | |
|-------------------------|------------------|
| _____ | _____ |
| NAME (PRINTED or STAMP) | TELEPHONE NUMBER |
| _____ | _____ |
| ADDRESS | CITY, STATE, ZIP |
| _____ | _____ |
| SIGNATURE (REQUIRED) | DATE |