BOSIA STUDENT MEDICAL CLEARANCE

STUDENT NAME ___________________________________ **DOB**______________

HEALTH HISTORY: ***Page 1* must *be completed by parent or guardian before the student's medical exam*.**
The information provided is confidential and will be used to assure that we are aware of your student's physical and mental health needs during the trip.

HOUSEHOLD #1			**HOUSEHOLD #2**		
Parents/Guardians:			Parents/Guardians:		
Address:			Address:		
City/State/Zip:			City/State/Zip:		
Home Phone:			Home Phone:		
Work Phone(s):			Work Phone(s):		
Cell Phone(s):			Cell Phone(s):		
E-mail(s):			E-mail(s):		

ALTERNATE EMERGENCY CONTACT

Name ____ Relationship___________________________________

Phone number _________________________________ Cell Number __________________________________

MEDICAL INSURANCE

Company Name________________________________ Policy number_________________________________

Subscriber ___________________________________ Group number_________________________________

TRAVEL/INTERNATIONAL INSURANCE Y ☐ N ☐ If yes, please provide copy.

If Yes: Company name________________________ Policy Number_________________________________

HAS STUDENT HAD DISEASES/CONDITIONS LISTED BELOW

	YES	NO		YES	NO
ALLERGIES (drugs, foods, insects)	☐	☐	SURGERY	☐	☐
HOSPITALIZATION	☐	☐	ASTHMA	☐	☐
CHRONIC HEALTH PROBLEMS	☐	☐	SEIZURES	☐	☐
DISABILITY OR SPECIAL NEEDS	☐	☐	DIABETES	☐	☐
MENTAL HEALTH ISSUES	☐	☐	EATING DISORDER	☐	☐

If yes, please describe in detail and indicate severity. Please share any additional information about your student's physical and mental health that might help the chaperones support your student during travel.

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MEDICATIONS ***LIST ALL PRESCRIPTION AND NON PRESCRIPTION MEDICATIONS, DIETARY SUPPLEMENTS, VITAMINS AND HERBAL MEDICATIONS***

Medication ___________________________________ Dosage______________________________________

Medication ___________________________________ Dosage______________________________________

Medication ___________________________________ Dosage______________________________________

Medication ___________________________________ Dosage______________________________________

VACCINE HISTORY ***PLEASE SPECIFY MOST RECENT DATE (MONTH AND YEAR)***

DTP/Tdap/Td ______/_____ Polio______/______ Meningitis ______/______

MMR #1 ____/____#2____/_____ Varicella #1_____/____#2____/____ Typhoid ______/______

HepA #1 ____/____#2____/_____ Hep B #1 ____/____#2____/____ #3 ____/____

Your signature below attests that the information provided above is complete and that inaccurate or incomplete information could be harmful to your student's health.

PARENT/LEGAL GUARDIAN SIGNATURE _______________________________ **DATE**_______________

BOSIA STUDENT HEALTH CERTIFICATE

STUDENT NAME ___________________________________ DOB______________

HEALTH CERTIFICATE: Page 2 must be completed and signed by the student's primary care provider. The primary care provider should not be related to the student. A physical exam must have occurred within 12 months prior to the date of travel.

Date of Last Exam **_______________**

1. Height__________ Weight__________ B/P __________ Pulse __________

   Please note any pertinent abnormalities on exam. ____

2. Has the student *ever* shown evidence of, or been evaluated or treated for a nervous, emotional, drug/alcohol or eating problem? Yes ☐ No ☐

3. Is there *present* evidence of an emotional, nervous, drug/alcohol or eating problem? Yes ☐ No ☐

   If yes to either 2 or 3 above, a full report in a sealed envelope should be attached. Please note that if a student is experiencing current emotional, physical, personal or family difficulties, these difficulties can be exacerbated by the adjustment demands of the program. Therefore you are requested to evaluate carefully the student's current or previous condition along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

4. Are there any health limitations on the student's activities or any medical information that should be considered? Yes ☐ No ☐
   If yes please describe: ____

   ____

5. Malaria medication is recommended for this student YES ☐ NO ☐
   *If yes name*____

6. I have approved the use by the student of the medications listed on page one Yes ☐ No ☐
   Please prescribe Epi-Pen for this student if ANY history or concern for allergic reactions
   Please prescribe an Albuterol MDI if ANY history or concern of asthma.
   Please consider Tamiflu for this student if ANY history of asthma or other risk factors

7. I have reviewed the list of first aid medication protocols to be followed by the delegation's chaperones and approve their use for this student as needed. Yes ☐ No ☐
   Note any exceptions: ____

I, the undersigned, certify that a thorough physical examination of the student has been given and all important recent medical information has been included on the health history and health certificate, that nothing relevant has been omitted and that the student is able to travel.

_________________________________	_________________________________
Primary Care Provider Name and Degree	Signature
_________________________________	_________________________________
Address and Phone Number	Date

First Aid Medication Protocols – Ometepe

Each individual must take responsibility for their own health and well being while traveling. This includes, but is not limited to avoidance of contaminated food and water, sun and heat protection, adequate fluid intake, insect protection, adequate rest, compliance with regular medications and following general travel safety rules

Chaperones and staff from both medically trained and lay backgrounds are assumed to be equipped with a copy of "Lonely Planet – Healthy Travel, Central and South America",copies of health history and clearance from a primary care provider, and medically relevant information on trip participants, a standard first aid kit provided by BOSIA and basic common sense. In addition, primary care medical personnel and commercial pharmacies are rarely more than 2 hours away, and telephone contact to backup can typically be made within an hour

The following are medications and doses recommended by the Medical Committee for use with common health problems. They are guidelines, designed to supplement "Lonely Planet" and offer a helping person confidence in assisting an ill participant. They are not meant to be comprehensive or address every possible scenario.

Acetaminophen (Tylenol): 500 mg tablets. 1-2 tablets every 4-6 hours for pain or fever, not to exceed 2 grams a day. Available in rectal suppository form from pharmacies in event of fever with vomiting.

Ibuprofen (Motrin, Advil): 200 mg tablets. 1-4 tablets every 6-8 hours for pain, fever, or inflammation (Better for acute injury and swelling than acetaminophen). Give with food. May alternate with acetaminophen every 3 hours.

Diphenhydramine (Benadryl): 25 mg tablets. 1-2 tablets every 6 hours for itching, hives or allergic reactions. Onset within 15-30 min. Causes dry mouth and drowsiness.

Loratidine (Claritin): 10 mg tablet. 1 tablet daily for longer lasting treatment of itching or allergy. Non-drowsy.

Pseudoephedrine (Sudafed): 30 mg every 6-8 hours for nasal congestion. Non-drowsy. May increase heart rate.

Loperamide (Imodium): 2 mg tablets. 2 tablets with first episode diarrhea, followed by 1 tablet after each loose stool, not to exceed 16 mg a day. Attention to hydration important even if diarrhea decreases. This is an antimotility agent that decreases duration of diarrhea. Consider starting antibiotics if Imodium started or student not improving in 24 hours. Loperamide should not be used in travelers with fever or bloody diarrhea. .

Promethazine (Phenergan): 25 mg tablets or rectal suppositories. 1 tablet or suppository every 6 hours for vomiting.

Bismuth Subsalicylate (Peptobismol) Four tablets every 30 minutes until diarrhea resolves . Maximum of 8 doses. Peptobismol may cause stool to turn black. It should not be used in students under 18 years old if any concern of influenza (flu) due to risk of Reye syndrome.

Hydrocortisone 1% cream (Cortaid): Apply 3-4 times a day for rashes, itching or insect bites.

Clotrimazole (Lotrimin) cream: Apply twice a day for fungal rashes (ringworm, jock itch) on unbroken skin

Triple antibiotic cream : Apply 3 times a day for 7 days for impetigo(sores with yellow crust) or other skin infections. Seek oral antibiotics if fever or large area that is red, hot and tender to touch.

Ciprofloxin : 500 mg tablet. 1 tablet every 12 hours for 1-3 days for SEVERE or persistent diarrhea (fever, more than 4 watery stools a day, blood in stool, dehydration).

Azithromycin 250 mg tablets: 4 tablets taken as single dose for SEVERE or persistent diarrhea (fever, more than 4 watery stools a day, blood in stool, dehydration)

Gentamycin ophthalmic drops: 2 drops in affected eye(s) 4 times a day for 5-7 days. Use for pink eye only if pus like discharge from eyes. Try Natural Tears or saline if eyes red but not draining.