BOSIA STUDENT PARTICIPATION MEDICAL CLEARANCE

BOSIA Health Committee 1/29/2020, updated 12/04/2023

Access to student's health information is limited to a Health Professional on the BOSIA Health Committee and the chaperones travelling with the student delegation

Student Name: ____ **Today's Date:** ________________

Date of Birth: ___________________ **Gender:** ______________ **Gender Pronouns:**________________

Home Address:

____

Name(s) and Phone Numbers of Parent(s) or Guardian(s):

1.____ Relationship ________________

Cell: ___________________________ Other: ________________________________

2.____ Relationship ________________

Cell: ___________________________ Other: ________________________________

Emergency Contact (other than immediate family members):

Name: ____

Relationship to Student: ____

Cell/Contact information: ____

Usual Medical Provider: Name: ____

Phone: _________________

Medical Insurance Coverage: (*check with carrier as to details of international coverage*)

Subscriber: ____

Company and Group/Policy Number: ________________________________

Information for Health Professional:
Your patient has been chosen for a cultural delegation to the island of Ometepe, a low income, low resource, rural volcanic island in Lake Nicaragua. They will be living with a local, non-English speaking family, which can be stressful. They will be accompanied by chaperones and a medical professional but resources for evaluation and treatment are limited. The most common health risks relate to insect bites, GI illnesses (contaminated food/water), and homesickness/anxiety. Medical services are limited. Thus, in the interest of the personal safety of both the delegate and the other team members, please carefully consider the questions on the attached form when completing this form. "Yes" answers do not preclude the student's participation, but they will help us be prepared. If we have any questions we will call the student. With this in mind, please assess the student's suitability for participation.

GENERAL MEDICAL HISTORY:

ALLERGIES (meds, foods, insects) and reaction:

DIETARY RESTRICTIONS /reason (personal v allergy): ________________________________

PAST HOSPITALIZATIONS/SURGERIES:

IMMUNIZATION HISTORY and date of most recent immunization:

Influenza *(consider repeat if >6 months ago as flu season is April-Oct on Ometepe)* ____________

Td/Tdap *(recommend within 5 years)* ________________________

Typhoid *(recommend, specify if oral or parenteral)* ______________

Hepatitis A *(2 doses recommended)* __________________________

MMR ____________________ **Varicella** ___________________

Polio _____________ **Hib** ______________ **Pneumococcal** ______________

Hepatitis B ______________ **Meningococcal** _____________

COVID-19 Booster ______________________

Rabies *(not routinely recommended; avoid contact with animals and report bites)*

PLEASE CHECK YES/NO FOR EACH ITEM and provide details for all "Yes" answers.

Does the applicant have a history of:

1. Asthma or other respiratory problems? **YES** **NO**
Well controlled? Inhaler use? Triggers? Last episode? Ever hospitalized?
PLEASE HAVE STUDENT BRING INHALER(S) WITH THEM

____

____

____

Does the student smoke or vape? **YES** **NO**

2. Systemic reaction to insects or medications resulting in hives, swelling of face/lips or difficulty swallowing/breathing? **YES** **NO**

____

____

IF APPROPRIATE, STUDENT SHOULD BRING PERSONAL EPINEPHRINE Auto Injector and know how to use it.

3. Cardiac history? **YES** **NO**

____

4. GI disturbances? (IBS, IBD, constipation, diarrhea) **YES** **NO**

____

5. Hepatitis or other liver disease? **YES** **NO**

____

6. Urinary tract disorders/ gyn problems/STIs? **YES** **NO**

____

7. DVT/bleeding disorders? **YES** **NO**

____

8. Neurologic problems? (epilepsy, dizziness, fainting, HA/migraine, TBI) **YES** **NO**

____

9. Diabetes? **YES** **NO**

(Type, onset, regimen, history of hypoglycemia/complications, hospitalizations, A1C/assessment of control, ability of student to self manage)

____

____

____

10. MSK? (History of injuries including fracture, sprains, surgeries) **YES** **NO**

____

11. Fitness concerns? **YES** **NO**

Does the student exercise regularly?

---

12. Swimming ability (circle one):

Non-swimmer **Recreational** **Competitive**

13. Mental health/Substance or alcohol use/ADHD/Special Needs **YES** **NO**

(including significant family stressors, insomnia, eating disorder, anxiety, depression, treatment including meds and counseling)

____

____

____

14. OTHER

PHYSICAL EXAMINATION:

VITALS: BP HR Height Weight

Glasses or contacts?_______________________________ (If contacts, bring glasses back up)
Hearing aides _____________________________________

GENERAL APPEARANCE/Impressions and Comments:

AUTHORIZED & PRESCRIBED MEDICATIONS (including OTC, indication, dose, route and frequency of administration)
Students must understand the use of any medications they may be taking and must be able to do so on their own without additional supervision. **SEE ATTCHED RECOMMENDATIONS.**

____
Examiner's Name

____
Address

____
Phone

By my signature I attest that I have obtained the information on this form from the named student and parent/guardian, performed a physical exam and also that the information is correct to the best of my knowledge. The named student is medically cleared to participate on a cultural delegation to Nicaragua.

____
Signature MD /DNP /ARNP/ PA Date