BOSIA STUDENT MEDICAL CLEARANCE FORM

BOSIA Health Committee 1/29/2020, updated 11/20/2024
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

PLEASE PRINT

Student Name: _____ Today's Date: _____

Date of Birth: _____ Gender: _____ Preferred 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 vs allergy): _____

PAST HOSPITALIZATIONS/SURGERIES:

VACCINATION HISTORY (please attach copy of immunization record OR fill in the date of most recent immunizations below)

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

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

Typhoid *(recommended, 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)* _____

DOES THE APPLICANT HAVE A HISTORY OF ANY OF THE FOLLOWING?
(Please circle "yes" or "no" for each item AND provide details for ALL "yes" answers.)

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 problems? (incl. past injuries, fractures, sprains, surgeries) **YES** **NO**

_____

11. Fitness level – any symptoms with exertion? **YES** **NO**

_____
(if "no", describe student's regular exercise)

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 as 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 ATTACHED 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**