



INTERNATIONAL TRAVEL STUDIES INSTITUTE HEALTH INFORMATION WAIVER & RECOMMENDATION SHEET TO THE STUDENT

I. INSTRUCTIONS

The information contained in this form is CONFIDENTIAL and will be reviewed by International Travel Studies Institute staff only!

Once completed, please forward to the International Travel Studies Institute (ITSI) office: 285 East 1910 South, Orem, UT 84058 or email scanned form to: travelstudiesinstitute@gmail.com. This form must be completed before the final admission interview may be scheduled.

Please complete the following information, being honest with yourself and the interviewer.

II. CONFIDENTIAL PERSONAL HEALTH HISTORY

FIRST NAME AND MIDDLE INITIAL	LAST NAME	ITSI PROGRAM	BIRTHDATE	AGE	GENDER
<i>Do you have or have you experienced:</i>		Y	N	<i>If yes, refer to the item by number, explain when the problem occurred, and give details of present condition.</i>	
1. Ear pain or any problem with hearing?	<input type="checkbox"/>	<input type="checkbox"/>			
2. A need to take any kind of medicine? Please list.	<input type="checkbox"/>	<input type="checkbox"/>			
3. Eye discomfort or difficulty?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Dizziness or fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Hay fever or nasal problems?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Food allergies?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Hives or skin allergies?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Skin sores or rashes?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Warts or sores on feet?	<input type="checkbox"/>	<input type="checkbox"/>			

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<i>Continued ...</i>	Y	N	<i>If yes, refer to the item by number, explain when the problem occurred, and give details of present condition.</i>
11. A lump, new or changing mole, or swelling?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Coughing, frequent sore throat?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Chest pain or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Spitting or coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Sweating at night?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Stomach aches, burning, or indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Urinary difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Pain in back, neck, or joints?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Difficulty walking, running, or lifting things?	<input type="checkbox"/>	<input type="checkbox"/>	
20. A rupture or hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Difficulty with bowels or bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any female difficulties, painful menstruation, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Any injury or illness not already noted?	<input type="checkbox"/>	<input type="checkbox"/>	
24. A drug or medicine reaction?	<input type="checkbox"/>	<input type="checkbox"/>	
25. Heart disease or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Diabetes or hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>	
27. A goiter or other thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>	
28. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
29. Excessive bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	

<i>Continued ...</i>	Y	N	<i>If yes, refer to the item by number, explain when the problem occurred, and give details of present condition.</i>
30. Tumor, growth, cyst, or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
31. A dependency on medicine or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
32. A stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
33. Professional counseling for emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	
34. Medication/hospitalization for an emotional problem?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	
36. A knee injury?	<input type="checkbox"/>	<input type="checkbox"/>	
37. Limb loss, or deformities, or other handicaps?	<input type="checkbox"/>	<input type="checkbox"/>	
38. A back injury or deformity?	<input type="checkbox"/>	<input type="checkbox"/>	
39. A pain or pressure in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	
40. Asthma or wheezing? (Do you have an inhaler?)	<input type="checkbox"/>	<input type="checkbox"/>	
41. Stomach or intestinal ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	
42. Seizures, convulsions, epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
43. Kidney disease or stones?	<input type="checkbox"/>	<input type="checkbox"/>	
44. Gall bladder trouble or stones?	<input type="checkbox"/>	<input type="checkbox"/>	
45. Allergies to medications, bee stings, foods, etc.? (If so, do you have a kit?)	<input type="checkbox"/>	<input type="checkbox"/>	
46. Anorexia, bulimia, or other eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
47. A suicide attempt?	<input type="checkbox"/>	<input type="checkbox"/>	
48. Motion sicknesses of any type?	<input type="checkbox"/>	<input type="checkbox"/>	

49. Vegetarian (If so, how long?)	<input type="checkbox"/>	<input type="checkbox"/>
50. Attention Deficit Disorder (ADD) or learning disability?	<input type="checkbox"/>	<input type="checkbox"/>
51. Other health problem, surgery, or hospitalization not noted above?	<input type="checkbox"/>	<input type="checkbox"/>

If any current health problems exist, or you are involved in professional counseling, a written confidential assessment from your health provider or therapist and signed permission for the International Travel Studies Institute interviewer to discuss the matter with the health provider or therapist must be provided. The Health Information Waiver and Recommendation Sheet is printed on the next page. Please fill out the top portion and send the sheet to International Travel Studies Institute, 285 East 1910 South, Orem, UT 84058.

*Please sign: **The above information is truthful and complete.***

Signature of applicant _____ Date _____



INTERNATIONAL TRAVEL STUDIES INSTITUTE HEALTH INFORMATION WAIVER & RECOMMENDATION SHEET TO THE STUDENT

Due to the physical, emotional, and academic demands of the International Travel Studies Institute programs, an Institute administrator needs to visit with your health provider, physician, counselor, and/or therapist to discuss the condition(s) you have disclosed before we can admit you to the program for which you have applied. The following is a release by which you give us permission to discuss the condition(s) you have disclosed.

I, _____, hereby authorize
(Please print your name)

Name _____

(Please provide the name, address, telephone, email, & FAX of your physician, counselor, or therapist)

Address _____

Phone _____ Email _____ FAX _____

to release the following information concerning my treatment:

The above-mentioned physician, counselor and/or therapist are hereby authorized to release the above specified information to The Intern National Travel Studies Institute, 285 East 1910 South, Orem, UT 84058 for the purpose of evaluation for admission into an International Travel Studies Institute program.

Signed _____ Witnessed by _____ Date _____

TO THE PHYSICIAN, COUNSELOR, and/or THERAPIST

Your patient is being considered for admission to an International Travel Studies Institute program which requires long-term residency and travel in the Middle East. Due to the unique nature and demands of the program, each applicant is screened thoroughly, particularly with regard to emotional and medical health issues. The student will be placed in a foreign living situation that is physically, emotionally and academically rigorous without the usual support services available in the United States or which they may normally be accustomed to in familiar home environments. Our concerns are both for the student and his/her fellow students. Students who require special medical or emotional attention may cause a disruption to the program and even endanger the wellbeing of others. Rather than benefit from the experience, the student may, in fact, be harmed. We must ensure that this student can independently manage physical and emotional challenges in a demanding environment. We, therefore, request that you thoughtfully and carefully review this applicant's condition(s) for fitness to participate in an International Travel Studies Institute program. Given the above signed release, we would like to discuss this matter with you and ask as well, that you have a follow-up visit with your patient. You will be contacted by an interviewer from the International Travel Studies Institute, Orem, Utah office. Following the discussion(s) with our organization and a follow-up visit with your patient, please complete this form and return it to our office: 285 East 1910 South, Orem, Utah 84058, or a scanned copy to travelstudiesinstitute@gmail.com.

Following the discussion with a representative of the International Travel Studies Institute, I, _____, met with my patient _____ on _____. I have reviewed the patient's current and/or pre-existing medical, psychological, and/or other treatments and counseling as they pertain to the patient's ability to participate in an International Travel Studies Institute program. According to my understanding of the physical, emotional and academic requirements placed on student who participates on this program, I make the following recommendation:

- I fully endorse this student for participation in this program.
I cannot endorse this student for participation in this program for the reasons indicated below:

Comments: _____

Signature _____ Date _____

(Signed by the physician, counselor and/or therapist)

Signature _____ Date _____

(Signed by the physician, counselor and/or therapist)