TRAVEL & SAFETY CONTINUED

STUDENT PRE-DEPARTURE CHECKLIST

Please print

NAME:

DATE OF DEPARTURE:

☐ Visited the Department of State travel website and reviewed the information posted for (COUNTRY)

☐ Registered with the Department of State through the Smart Traveler Enrollment Program (STEP): https://step.state.gov/step/

☐ Visited the CDC website Travelers Health and reviewed the information posted for (COUNTRY) including vaccinations: http://wwwnc.cdc.gov/travel/

☐ Attended a University of Washington Pre-Travel Preparation Orientation (if one is available)

Date attended: ___________________

☐ Enrolled in HTH International

☐ Read and signed the Code of Conduct

☐ Read and signed the Release and Waiver of Liability Form

☐ Obtained vaccinations and medications, or ☐ declined.

☐ Read and signed Student Contract

☐ Completed Emergency Contact Form

☐ Read Agreement Letter

☐ Read Safety Briefing sheet for (COUNTRY)

☐ Received Emergency Numbers Wallet Card

☐ Checked passport is valid for at least 6 months

☐ Checked with bank that personal ATM card will work in (COUNTRY)

☐ Informed bank of travel dates and countries

☐ Meeting with administrative staff to review details of trip, including funding available, costs covered, insurance coverage, and other international safety information

Date attended: ___________________

☐ I have completed all of the activities specified above.

SIGNATURE DATE

AFTER ARRIVAL IN (COUNTRY):

• Purchase cell phone and provide phone number to UW admin staff and on-site supervisor.

I agree to complete the items listed above upon my arrival in (COUNTRY).

SIGNATURE DATE

EMERGENCY CONTACT INFORMATION/MEDICAL INFORMATION FORM

YOUR NAME:

Emergency Contact 1:

NAME:

RELATIONSHIP TO YOU:

ADDRESS

HOME: WORK:

CELL: PAGER:

EMAIL:

Emergency Contact 2:

NAME:

RELATIONSHIP TO YOU:

ADDRESS

HOME: WORK:

CELL: PAGER:

EMAIL:

TRAVEL & SAFETY CONTINUED

Please include any other relevant information here: ____

____

____

Permission for Medical Treatment *(this information remains confidential)*

I hereby give permission to the medical personnel selected by a member of the (UW Department) to secure medical evaluation and any treatment necessary to preserve life and bodily function unless exceptions are noted below:

Exceptions (if none, write none): ____

I am allergic to the following medications (if none, write none): ______________________________

____

Other medical conditions about which those providing treatment should be aware (if none, write none):

____

____

____

____

SIGNATURE: