French Educator Program
Senegal 2024 - Medical Form

PLANNED TRAVEL DESTINATION: Senegal, West Africa

Completion of this medical form is a mandatory requirement for participation in the ***Vive l'expérience*** travel experience and cannot be waived. Your information is confidential and will be shared only with those who need to know in order to assist you while traveling, including, for example, providing emergency or other necessary care. We recommend you discuss vaccinations, immunizations, and malarial prophylaxis with your doctor as soon as possible, in case they have any concerns.

Participants must meet the following general requirements: possess the physical and mental well-being required to travel abroad where resources may be different or fewer than those to which you are accustomed; exercise good judgment; demonstrate flexibility and function in the face of potentially uncertain or stressful situations. You may experience new environmental allergies or experience seasonal allergies at a time of year when you normally do not encounter issues. We recommend you bring all medication and/or inhalers as prescribed. One of the Trip Leaders may contact you prior to the trip to determine how we can best meet your medical needs while in Senegal.

Participants will engage in activities including, but not limited to:

- o City walking
- o Walking on uneven surfaces, dirt roads, sand and/or light hiking
- o Local travel over rough roads
- o Boat rides (ferries and pirogues)
- o Carrying own bags
- o Climbing stairs
- o Standing for extended periods
- o Sitting on hard surfaces (e.g. wood, the ground) for extended periods
- o Dancing, drumming
- o Use of squat toilets

Depending on the trip's itinerary, participants may also engage in activities including, but not limited to:

- o Sleeping without fans
- o Camping in tents in the desert
- o Swimming in a pool, river, ocean
- o Spending the night with a host family

GENERAL HEALTH

This Medical Form must be completed **within 12 months of the date of departure** by the applicant. Please provide updates as needed prior to departure.

Participant Full Name:____

Male ☐ Female ☐ Height: ____________ Weight: ___________ Blood Type: ____________ (optional)

Name of Medical Insurance Provider: ______________________________ Policy Number: ______________________________
Doctor's name: ____ 24/7 Insurance phone: __________________________

Yes ☐ No ☐ Are you allergic to peanuts? We recommend that you do NOT travel to Senegal with a peanut allergy. Please contact Vive to discuss if you answer yes to this question.

Yes ☐ No ☐ Do you have any other allergies to food or environmental triggers ? If so, please list and describe reactions:

Yes ☐ No ☐ Are you bringing an Epi-Pen on the trip? If so, for what allergy?

Yes ☐ No ☐ Are you diabetic? If yes, do you take medicine or require insulin?

Yes ☐ No ☐ Do you use a CPAP machine? Note that there may be electrical outages and/or fluctuation in electrical power.

Yes ☐ No ☐ Do you have any food Intolerances? Are you unable to eat certain foods? Do you have any food preferences? If so, please list and describe:

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Yes ☐ No ☐ Do you have any physical or psychological condition or disability that might result in severe hardship due to change in diet, carrying luggage, climate/temperature differences, or strenuous travel? If so, please describe:

Yes ☐ No ☐ I have discussed my options with my physician or travel medicine professional and will take the following malaria prophylaxis: ________________________________. Malaria is present in Senegal. All ***Vive l'expérience*** Participants must obtain a prescription for malaria prevention medication and take the prescription according to schedule.

Yes ☐ No ☐ I have reviewed the latest CDC guidelines for travel to Senegal and have discussed recommended vaccination and immunization with my physician and/or travel medicine clinic.

Yes ☐ No ☐ I will provide copies of my Covid vaccination cards and Yellow Fever cards at least 1 month prior to departure, or may be unable to participate in the program/ travel without refund.

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact

Contact Name:________________________________ Relationship to Participant:________________________

Cell Phone:__________________________________ Work Phone: ________________________________

Email:______________________________________

Secondary Emergency Contact

Contact Name:________________________________ Relationship to Participant:________________________

Cell Phone:__________________________________ Work Phone: ________________________________

Email:______________________________________

TRAVEL INSURANCE Company Name: ____

TRAVEL INSURANCE POLICY Number: ____

TRAVEL INSURANCE Contact Information: ____

NOTICE OF PRIVACY PRACTICES

I certify to ***Vive l'expérience, LLC*** that the information provided is accurate. I authorize any physician, nurse or other health care provider to communicate with the Trip Leaders about my medical condition, treatment, and/or prognosis as needed. In the event I am unable to make such decisions, I hereby give permission to the physician selected by ***Vive l'expérience, LLC***, and its representatives to order X-rays, routine tests and treatment for me, to secure proper treatment for, and in the event of an emergency, to order injections and/or anesthesia and/or surgery for me. I hereby give permission to Vive to disclose any HIPAA and other healthcare information to these representatives as well as my emergency contacts **if I am unable to do so myself.** Participants can exercise their rights to access copies of their Protected Health Information by emailing privacy@vivelexperience.com.

I understand that I am responsible for any additional medical costs and related costs (medications, hospital bills, doctor visits, additional transportation and accommodations, etc.) related to sickness while on Program.

I certify that I have no physical conditions that affect my ability to travel and/or participate in any of the activities involved in ***Vive l'expérience, LLC*** Programs. I understand that I am responsible for notifying the appropriate ***Vive l'expérience, LLC*** Trip Leader immediately of any injury, sickness or other medical condition, or change to the medical information herein provided.

These authorizations are limited through our return to the United States on ______________ [INSERT DATE OF RETURN TO USA or home city].

PARTICIPANT SIGNATURE

My signature affirms the above to be factually true.

____ Participant signature

____ Participant Name (please print first and last name)

____ Date

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OPTIONAL: YOU MAY CHOOSE TO CARRY THE FOLLOWING PAPERWORK WITH YOU WHILE TRAVELING, to be shared with Trip Leaders or Emergency Staff in case of emergency

CURRENT MEDICATIONS

Medication	Purpose	Frequency and Dosage	Bringing on Trip?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

MEDICAL HISTORY

Have you ever had or suffered from, been treated for, or hospitalized for the following?		Date	Explanation (Describe symptoms & treatment)
Speech, hearing, or eyesight impairment (Contact lenses or glasses)	Yes ☐ No ☐		
Headaches	Yes ☐ No ☐		
Epilepsy/seizures	Yes ☐ No ☐		
Asthma/lung disease	Yes ☐ No ☐		
Heart disease	Yes ☐ No ☐		
Anemia or bleeding disorder	Yes ☐ No ☐		
Ulcer/colitis	Yes ☐ No ☐		
Hepatitis/gallbladder	Yes ☐ No ☐		
Bladder/kidney problems	Yes ☐ No ☐		
Diabetes	Yes ☐ No ☐		
Cancer/tumors	Yes ☐ No ☐		
Back/joint problems	Yes ☐ No ☐		
High blood pressure	Yes ☐ No ☐		
Thyroid problems	Yes ☐ No ☐		
Infectious/contagious disease	Yes ☐ No ☐		
Pregnancy	Yes ☐ No ☐		

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MENTAL HEALTH HISTORY

To your knowledge, are there any predisposing/pre-existing medical, surgical, or emotional factors which may, under stress or duress encountered during the Program, present a need for immediate therapy while abroad? Any mental health condition (e.g. depression, anxiety) Substance abuse (e.g. alcohol, drugs) Eating disorder (e.g. anorexia, bulimia)	Yes ☐ No ☐	Explanation

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