UC Davis Study Abroad
Health Clearance Form 2023 (Instructions Page)

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READ BELOW FIRST

All participants must submit a signed and completed Health Clearance in order to participate in a UC Davis Study Abroad program. This form is only for 1) UC Davis students who choose **not** to complete the health clearance process through UC Davis Student Health and Counseling Services **OR** 2) all non-UC Davis students.

It is important that you disclose ALL of your medical history, including both physical and mental health conditions, even if you do not believe that the current or past condition(s) will affect you while you are on your program. Existing or previous conditions, including mental health conditions such as depression, anxiety, and others may return or be exacerbated by travel to a new setting.

The UC Davis Study Abroad office prioritizes supporting the health of our student participants. This includes helping you to plan beforehand to make sure resources and/or accommodations are available when you are on-site. Please note that Study Abroad will only share your information with other parties on a need-to-know or emergency basis.

Omitting or falsifying information on this form not only poses a risk to your safety while on your program, it is a breach of University policies on honesty and may result in you being withdrawn from the program and/or suspended from the University, or other disciplinary actions. **Per the participant contract, you are required to update Study Abroad if there are any changes to your physical or mental health after you submit this form.**

INSTRUCTIONS

1. Fill out pages 1 -3 of the Health Clearance Form completely and honestly **prior to submitting** it to your healthcare provider.
2. Obtain your immunization history. This information is requested in your Health Clearance Form. Additional immunizations may be needed for certain countries. **All participants should consult with their provider and the Centers for Disease Control and Prevention (CDC) website regarding recommended immunizations they may need before traveling.**
3. Take all pages of this form to your physician. Your physician should review the Health Clearance Form with you and complete and sign the PHYSICIAN CLEARANCE section at the end of the form. **PLEASE NOTE:** If you are seeing a specialist (this includes mental health care professionals such as Psychiatrists, Psychologists, Counselors, etc.) for an ongoing physical or mental health condition, your specialist should complete the SPECIALIST CLEARANCE section (page 4) **before** your physician completes their clearance (page 5).
4. Upload your **entire** signed and completed Health Clearance Form **including all pages 1-5 (enclose the fourth page, even if it is not signed by a specialist)** to your Study Abroad Account.

IMPORTANT NOTES

- The completed health clearance is **valid for one year** from the date that the physician signs and MUST be valid until the end of your program.
- Health clearance signatures from relatives are **NOT accepted**.
- **All five (5) pages of the health clearance must be included in your submission**. If you do not see a specialist, please include page 4 with nothing filled in.
- If you are seeing a specialist (this includes mental health care professionals such as Psychiatrists, Psychologists, Counselors, etc.) for an ongoing physical or mental health condition, your **specialist must complete the SPECIALIST CLEARANCE section.**
- Make sure your physician completes all required information.

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YOUR INFORMATION

Last Name: _____ First Name: _____ MI: __

Sex Marker: ☐ M ☐ F ☐ Different Identity: _____DOB: _____

Primary Phone: _____ Alt. Phone: _____

Program Title: _____

Program Location(s) (City AND Country):_____

Program Dates (MM/DD/YYYY): From _____ to _____

UC Davis Student ID #: _____ Non-UC Davis Student ID #: _____

Will you be traveling to additional countries/locations? ☐ Yes ☐ No. If yes, please list each country along with duration of stay: _____

Anticpated travel conditions (check all that apply):

☐ working with animals/insects or field work
☐ staying outside major urban areas
☐ hotel
☐ private homes
☐ camping
☐ working in a healthcare/clinic setting
☐ dorm or youth hostel
☐ apartments,
☐ other, please specify:_____.

GENERAL HEALTH

My general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Height: _____ Weight: _____lbs.
List any recent or continuing health conditions: _____

_____

SPECIALIST INFORMATION

Are you *currently* under the care of a specialist healthcare professional for a physical or mental health condition?
☐ Yes ☐ No If yes, for what condition(s): _____

Specialist's Name AND Title: _____ Phone: _____

Email Address: _____

IMPORTANT: If you are **currently** under the care of a specialist (this includes mental health professionals), the specialist must complete the SPECIALIST CLEARANCE (page 4) **before** your physician completes the PHYSICIAN CLEARANCE (page 5).

MEDICAL HISTORY

Surgeries (list type and year): _____

Hospitalization(s) (list reason and year): _____

MEDICAL HISTORY - *CONTINUED*

Check *Yes* or *No* if you have ever had any of the following:

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Headaches				Ulcer/Colitis				Back/Joint problems			
Epilepsy/Seizures				Diabetes				High blood pressure			
Asthma/Lung disease				Cancer/Tumors				Severe allergic reaction			
Heart disease				Thyroid problems				Vision problems			
Anemia or Bleeding disorder				Hepatitis/Gall-bladder disease				Bladder/Kidney problems			

Other physical conditions (list type and year): _____

If applicable, are you currently pregnant or planning to become pregnanty? ☐ Yes ☐ No

MENTAL HEALTH HISTORY

Please disclose **current or past** mental health conditions. Check *Yes* or *No* if you have experienced and/or received treatment (counseling, medication, hospitalization, etc.) for:

	Yes	No	Date/Year	Please provide an explanation for any "yes"
Depression and/or Anxiety				
Substance abuse (alcohol and/or drugs)				
Eating disorder(s) (ex: anorexia, bulimia)				
OTHER conditions?				
Are you taking/have taken medication for the above condition?				Please provide name of medication:

DRUG AND/OR FOOD ALLERGIES

List any drug and/or food allergies and briefly describe the reaction.

_____

_____

_____

DEVICES

Do you wear or use any of the following devices?
Contact lenses or eyeglasses: ☐ Yes ☐ No
Hearing aid(s): ☐ Both ☐ Right ☐ Left ☐ None
Pacemaker: ☐ Yes ☐ No
Prosthetic joints or devices: ☐ Yes ☐ No If yes, please list: _____
Other (please explain): _____

MEDICATIONS

PLEASE NOTE: Participant is responsible for ensuring that all medications are legally permissible in their program location. If you are taking medications on a regular basis, please assure you have a sufficient supply of your medication(s) to last the duration of your program or provide assurance that the medication is locally available abroad. If your medication requires any special handling, storage or administration supplies, please contact the UC Davis Study Abroad to discuss possible arrangements (i.e. refrigeration, syringes & needles, etc).

Are you taking any medications? ☐ Yes ☐ No
If yes, please specify (could include antidepressants, birth control pills, etc). Also include any medication you carry for possible use, e.g. inhaler, bee sting kit, epinephrine.

_____

_____

_____

IMMUNIZATION HISTORY

Indicate most recent date below. If not received, indicate N/A. Immunization history and travel clinic appointment may be required if you are traveling to certain destinations. Consult with your physician regarding any immunizations you may need.

	Date		Date
Polio immunization		Measles, Mumps and Rubella (MMR)	
Tetanus booster or Tetanus/diphtheria booster		Chicken Pox vaccine	
Hepatitis A		Meningococcal	
Hepatitis B		Typhoid	
Yellow Fever			

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Include this page when turning in your health clearance form even if you do not have a specialist.

Participant Name: _____ **Program Location (City and Country):** _____

SPECIALIST CLEARANCE (if applicable)

PLEASE PRINT CLEARLY WITH A PEN OR MARKER. ALL SECTIONS AND APPLICABLE BOXES MUST BE COMPLETED.

UC Davis Study Abroad participants will spend three to ten weeks studying at the location indicated on this form. It is important that participants are able to adjust to significant changes in climate, diet, and living conditions, which can create mental and physical stress that can aggravate even mild conditions.

1. Review participant's Health Clearance Form and medical records, if available.
2. If participant is seeing a specialist for an ongoing physical or mental health condition, the approval and signature of the specialist(s) in SPECIALIST CLEARANCE should be obtained **BEFORE** final clearance is signed by the physician.
3. IMPORTANT NOTE: Legible names of the physician and the specialist (if participant is seeing one) are required. **FORMS WITHOUT SIGNATURES AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE**.
4. Information included on this form will only be shared with program staff, including the Faculty Program Leader, on a need-to-know basis.
5. Update UC Davis Study Abroad if your assessment of this participant changes at a later date.

After considering the rigors of study abroad and reviewing the information provided by the participant on this Health Clearance Form (and medical records, if available), in my professional judgment this participant is (select *one*):

- ☐ **CLEARED. There are NO medical or psychiatric contraindications to participation**. If you have additional recommendations, requirements or concerns you should **NOT** select this option.
- ☐ **CLEARED WITH CONDITIONS.** Participant should arrange the following before study abroad participation:
  - ☐ Services that would facilitate the participant's education (e.g. note taking, wheelchair access). Participant should contact their home campus Disability Services Office for a letter documenting the accommodations needed and submit the letter to UC Davis Study Abroad as soon as possible.
  - ☐ Services that would facilitate a healthy and safe stay (e.g. regularly available psychiatric therapy, allergy treatment). Indicate that the participant has a treatment plan in place and is stable:

    _____

    _____
  - ☐ A sufficient supply of medication to last the duration of the program or provide assurance that the medication is locally available.
- ☐ **NOT CLEARED. Participant is not cleared to study abroad.** There are **medical or psychiatric contraindications** to study abroad participation**.**

Licensed Specialist:

Name and Title (print clearly): _____ **Phone #:** _____

Address: _____

Signature: _____ **Date:** _____

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Participant Name: _____ **Program Location (City and Country):** _____

PHYSICIAN CLEARANCE (REQUIRED)

PLEASE PRINT CLEARLY WITH A PEN OR MARKER. ALL SECTIONS AND APPLICABLE BOXES MUST BE COMPLETED.

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1. Review participant's Health Clearance Form and medical records, if available.
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☐ **CLEARED WITH CONDITIONS.** Participant should arrange the following before study abroad participation:

- ☐ Services that would facilitate the participant's education (e.g. note taking, wheelchair access). Participant should contact their home campus Disability Services Office for a letter documenting the accommodations needed and submit the letter to UC Davis Study Abroad.
- ☐ Services that would facilitate a healthy and safe stay (e.g. regularly available psychiatric therapy, allergy treatment). Indicate that the participant has a treatment plan in place and is stable:

  _____

  _____
- ☐ A sufficient supply of medication to last the duration of the program or provide assurance that the medication is locally available.

☐ **NOT CLEARED. Participant is not cleared to study abroad.** There are **medical or psychiatric contraindications** to study abroad participation**.**

Physician:

Name and Title (print clearly): _____ **Phone #:** _____

Address: _____

Signature: _____ **Date:** _____