UC Davis Study Abroad
Health Clearance 2019

IMPORTANT NOTES

All participants must submit a completed Health Clearance in order to participate in a UC Davis Study Abroad program. This particular form should **ONLY** be used by 1) UC Davis students who choose **not** to complete the health clearance process through UC Davis Student Health and Counseling Services **or** 2) non-UC Davis Students.

The information you provide on this form is critical to UC Davis Study Abroad's efforts to assist you in preparing for your time abroad and in securing your well-being once you are abroad. **It is extremely 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 will create a problem for you while you are abroad. Existing or previous illnesses, including mental health conditions such as depression and anxiety, may be intensified or restarted by travel to a foreign setting, and it is important to be prepared for such possibilities.

If you are concerned that revealing a condition may preclude you from participating in study abroad, please know that UC Davis Study Abroad does everything it can to assist students with all types of physical and mental conditions to go abroad. This includes helping you to plan beforehand to make sure resources and/or accommodations are available when you are abroad. Please also know 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risk to your safety while you are abroad, it is a breach of University policies on honesty and may result in you being withdrawn from the program and/or suspended from the University, or in other disciplinary actions. **It is also important to update Study Abroad if there are any changes in your condition after you submit this form.** You are committed to doing so by signing the participant contract. Participants and/or physicians should update Study Abroad if there are any changes to a student's health between the date of this clearance through the Study Abroad program end date.
All students should consult with their doctor and the CDC website regarding recommended immunizations.

INSTRUCTIONS

1. Fill out pages 1 – 2 of the Health Clearance Form completely and honestly **prior to submitting** it to your healthcare provider
2. Get immunization history. This information is requested in your Health Clearance Form. Additional immunizations may be required for certain countries. Also be sure your routine vaccinations are up-to-date.
3. Take pages 1 – 4 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 must complete the SPECIALIST CLEARANCE section **before** your physician completes their clearance.
4. Upload your **entire** signed and completed Health Clearance Form **including all pages 1-4 (enclose the third page, even if it is not signed by a specialist)** with your complete UC Davis Study Abroad enrollment.
5. Keep a copy of these forms with your passport in the event that you require emergency treatment while overseas.

YOUR INFORMATION

(Print) Last name: _____ First: _____ MI: __

Sex Marker: ☐ M ☐ F ☐ Other: _____ DOB: _____

Daytime phone: _____ Alt. Phone: _____

Program title and location(s): _____

Program dates: From _____ to _____

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

GENERAL HEALTH

My general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Height: _____ Weight: _____lbs.

List any recent or continuing health problems: _____

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: _____ Phone/Fax: _____

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 **before** your physician completes the PHYSICIAN CLEARANCE.

MEDICAL HISTORY

Surgeries: List type and year _____

Hospitalization(s): List reason and year _____

Check 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 illnesses (list type and year): _____

MENTAL HEALTH HISTORY

PLEASE NOTE: it is important to disclose current or past mental health conditions, which may be intensified or restarted by travel to a foreign setting. Study Abroad can help you to plan ahead for such possibilities.
Check if you have suffered from or received treatment (counseling, medication, hospitalization etc.) for:

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

DRUG OR FOOD ALLERGIES

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

_____

_____

DEVICES

Do you wear or use any of the following devices? Contact lenses or eyeglasses ☐ Yes ☐ No

Hearing aid(s) ☐ Both ☐ Right ☐ Left 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 abroad.

Are you taking any medications? ☐ Yes ☐ No If yes, please specify below. Also include any medication you carry for *possible* use, e.g. inhaler, bee sting kit, epinephrine.

_____

_____

IMMUNIZATION HISTORY

Indicate most recent date. If not received, indicate N/A. Immunization history and travel clinic may be required if you will be 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			

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

Participant Name (Print): _____ **Program Location:** _____

SPECIALIST CLEARANCE (if applicable)

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

UC Davis Study Abroad program participants will spend four to twelve weeks studying in an international location. It is important that participants be able to adjust to significant changes in climate, diet, and living conditions, which can create mental and physical stress that can aggravate even mild disorders.

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 must 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** and may delay the participant's enrollment.
4. Information in this report 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:

☐ **CLEARED. There are NO medical/psychiatric contraindications to participation**.

☐ **CLEARED WITH CONDITIONS.** Participant should arrange the following before Study Abroad participation:

☐ Services that would facilitate the participant's education (e.g. note taking, wheel chair access). Participant should contact their home campus Disability Services Office for a letter documenting disability and who will pay for services.

☐ 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.

☐ **Participant is NOT cleared to study abroad:** There are **medical contraindications** to Study Abroad participation**.**

☐ **Participant is NOT cleared to study abroad:** There are **psychiatric contraindications** to Study Abroad participation.

Licensed Specialist:

PRINT name and title clearly: _____ **Phone #:** _____

Address: _____

Signature: _____ **Date:** _____

Participant Name (Print): _____ **Program Location:** _____

PHYSICIAN CLEARANCE

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☐ **Participant is NOT cleared to study abroad:** There are **psychiatric contraindications** to Study Abroad participation.

Physician:

PRINT name and title clearly: _____ **Phone #:** _____

Address: _____

Signature: _____ **Date:** _____