

### IMPORTANT NOTES

**All participants must submit a signed and 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 program and in securing your well-being once you are on your program. **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 health conditions to go on their program. This includes helping you to plan beforehand to make sure resources and/or accommodations are available when you are on your program. 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risk to your safety while studying abroad, it is a breach of University policies on honesty and may result in you being withdrawn from the program and/or suspended from the University, or in other disciplinary actions. **You are required to update Study Abroad if there are any changes to your physical or mental health after you submit this form.** You are committed to doing so by signing the participant contract in your Study Abroad online account. Participants and/or physicians/specialists 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. **It is important to note that health clearance signatures from relatives are NOT accepted.**

**All students should consult with their physician and the Center for Disease Control (CDC) website regarding recommended immunizations they may need before traveling. Study Abroad does not require any specific immunizations.**

### INSTRUCTIONS

1. Fill out pages 1 and 2 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. Also be sure your routine vaccinations are up-to-date.
3. Take all pages 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 this Health Clearance Form with your passport in the event that you require emergency treatment while on your program.

**YOUR INFORMATION**

(Print) Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_  
 Sex Marker:  M  F  Other: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Daytime Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Program title: \_\_\_\_\_ Program location(s): \_\_\_\_\_  
 Program dates (month, date, year): 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: \_\_\_\_\_

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 experienced and/or received treatment (counseling, medication, hospitalization, etc.) for:

	Yes	No	Date/Year	Please provide an explanation below 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?				

**DRUG OR FOOD ALLERGIES**

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

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**DEVICES**

Do you wear or use any of the following devices?

Hearing aid(s):  Both  Right  Left  None

Prosthetic joints or devices:  Yes  No If yes, please list: \_\_\_\_\_

Other (please explain): \_\_\_\_\_

Contact lenses or eyeglasses:  Yes  No

Pacemaker:  Yes  No

**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.

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**IMMUNIZATION HISTORY**

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

	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 (City and Country): \_\_\_\_\_

### 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 two to sixteen 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 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.** 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 available campus funding.
  - 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:**

Name and Title (print clearly): \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Name (Print): \_\_\_\_\_ Program Location (City and Country): \_\_\_\_\_

### PHYSICIAN CLEARANCE

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- Participant is NOT cleared to study abroad:** There are **psychiatric contraindications** to study abroad participation.

**Physician:**

Name and Title (print clearly): \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_