QUESTIONS?

About Country or Host Institution Specific Requirements, Deadlines, or Students, call:

<table>
<thead>
<tr>
<th>Appropriate International Programs Specialist, Operations:</th>
<th>Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Czech Republic, Denmark, France, Germany, Italy, Netherlands, Norway, Russia, Sweden, Switzerland</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitty Christen</td>
<td>805.893.4430</td>
<td><a href="mailto:kchristen@eap.ucop.edu">kchristen@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(Denmark, Italy, Netherlands, Norway)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katerina Georgieva</td>
<td>805.893.4255</td>
<td><a href="mailto:kgeorgieva@eap.ucop.edu">kgeorgieva@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(Czech Republic, France, Germany, Russia, Sweden, Switzerland)</td>
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<tr>
<td><strong>Botswana, China, Ghana, Hong Kong, India, Japan, Korea, Senegal, Singapore, South Africa, Taiwan, Tanzania, Thailand</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May Pothongsunun</td>
<td>805.893.6152</td>
<td><a href="mailto:mpothongsunun@eap.ucop.edu">mpothongsunun@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(China, Hong Kong, Singapore, Taiwan, Thailand)</td>
<td></td>
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</tr>
<tr>
<td>Amy Frohlich</td>
<td>805.893.2831</td>
<td><a href="mailto:afrohlich@eap.ucop.edu">afrohlich@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(Botswana, Ghana, India, Japan, Korea, Senegal, South Africa, Tanzania)</td>
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<td><strong>Australia, Canada, Ireland, Israel, Jordan, Morocco, New Zealand, Turkey, UK (England and Scotland)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diane Lindsey</td>
<td>805.893.3246</td>
<td><a href="mailto:dlindsey@eap.ucop.edu">dlindsey@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(Ireland, Israel, United Kingdom: England and Scotland)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jeanie O’Connell</td>
<td>805.893.5926</td>
<td><a href="mailto:jpoconnell@eap.ucop.edu">jpoconnell@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(Australia, Canada, Jordan, Morocco, New Zealand, Solomon Islands, UK: UC Center London Fall Program, Multi-City Program: London/Paris)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Argentina, Barbados, Brazil, Chile, Costa Rica, Dominican Republic, Mexico, Spain, USA-NRS</strong></td>
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</tr>
<tr>
<td>Monica Macias</td>
<td>805.893.4138</td>
<td><a href="mailto:mmacias@eap.ucop.edu">mmacias@eap.ucop.edu</a></td>
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<tr>
<td>(Costa Rica, Mexico, Spain, Multi-City Program: Mexico City/Sacramento, USA-NRS)</td>
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<tr>
<td>Ann Rotlisberger</td>
<td>805.893.4268</td>
<td><a href="mailto:arotlisberger@eap.ucop.edu">arotlisberger@eap.ucop.edu</a></td>
</tr>
<tr>
<td>(Argentina, Barbados, Brazil, Chile, Dominican Republic, Multi-City Programs: Buenos Aires/Santiago, Florence/Barcelona and Rome/Madrid)</td>
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About UCEAP health clearance, UCEAP travel insurance, and student medical cases, call:

<table>
<thead>
<tr>
<th>International Health, Safety &amp; Emergency Response Unit</th>
<th>Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inés DeRomaña, Director</td>
<td>805.893.7936</td>
<td><a href="mailto:ideromana@eap.ucop.edu">ideromana@eap.ucop.edu</a></td>
</tr>
<tr>
<td>Amy Donnelly, Analyst</td>
<td>805.893.5159</td>
<td><a href="mailto:adonnelly@eap.ucop.edu">adonnelly@eap.ucop.edu</a></td>
</tr>
<tr>
<td>Nancy Osborne, Analyst</td>
<td>805.893.3304</td>
<td><a href="mailto:nosborne@eap.ucop.edu">nosborne@eap.ucop.edu</a></td>
</tr>
<tr>
<td>UCEAP Insurance Liaison (goes to all IHS&amp;ER team members)</td>
<td></td>
<td><a href="mailto:uceapinsurance@eap.ucop.edu">uceapinsurance@eap.ucop.edu</a></td>
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</tbody>
</table>
# Revision History for 2017 UCEAP Annual Health Update

The following table shows all revisions to health requirements for UCEAP programs that occurred after the report was initially printed on January 23, 2017. These revisions are reflected within the content of the report published online at [http://www.eap.ucop.edu/Documents/Health Clearance/1718/annual_health_update.pdf](http://www.eap.ucop.edu/Documents/HealthClearance/1718/annual_health_update.pdf)

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Country affected</th>
<th>Page Number(s)</th>
<th>Change summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/3/2017</td>
<td>Japan</td>
<td>14</td>
<td>Hyperlinks to websites that provide information about bringing medication into Japan and the Yakkan Shoumei certificate have changed.</td>
</tr>
<tr>
<td>2/3/2017</td>
<td>HC Form</td>
<td>29</td>
<td>The UCEAP Health Clearance form was changed to a side-by-side format to provide sufficient space for students to accurately describe their program at the top of the form, which is important for proper routing at UCEAP Systemwide.</td>
</tr>
<tr>
<td>2/15/2017</td>
<td>Brazil</td>
<td>9, 66</td>
<td>There is an ongoing outbreak of yellow fever in certain areas of Brazil, mostly in rural areas. There is no program-required travel to these areas. However, students who plan to travel to these areas should be vaccinated against yellow fever, or else avoid travel to these areas. Updated information can be found at <a href="https://wwwnc.cdc.gov/travel/notices/alert/yellow-fever-brazil">https://wwwnc.cdc.gov/travel/notices/alert/yellow-fever-brazil</a>.</td>
</tr>
<tr>
<td>3/7/2017</td>
<td>Norway</td>
<td>16, 66</td>
<td>UCEAP has learned that students participating in the University of Oslo International Summer School (ISS) program are required to have a 1-page Health Certificate signed by a physician in order to receive health insurance benefits from a Norwegian policy in which they are required to enroll. A sample of the form has been added to Pg. 66 of the Appendix in the Country-Specific Forms section. The actual form can be downloaded from <a href="http://www.uio.no/english/studies/summerschool/admitted/health-insurance/pdf/health-certificate-iss-2017.pdf">http://www.uio.no/english/studies/summerschool/admitted/health-insurance/pdf/health-certificate-iss-2017.pdf</a>. The form should be completed by a medical professional using the information reported by the student on the UCEAP Confidential Health History form (or online equivalent). A physical examination is not required. The signature and stamp must be that of a physician.</td>
</tr>
<tr>
<td>3/29/2017</td>
<td>Brazil</td>
<td>9</td>
<td>The WHO has once again expanded the geographic area for which YF vaccination is recommended in Brazil. It now includes all areas of Rio de Janeiro outside of the city center and to Bahia state outside of the urban area of Salvador (<a href="https://wwwnc.cdc.gov/travel/notices/alert/yellow-fever-brazil">map</a>). It is likely that UCEAP participants will travel into an area at risk for transmission on either program-related or personal travel.</td>
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<tr>
<td>Date</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4/21/2017</td>
<td>Brazil</td>
<td>9</td>
<td>On April 4th, the WHO once again expanded the geographic area for which YF vaccination is recommended in Brazil. It now includes all areas of Rio de Janeiro and Bahia state including urban areas (<a href="#">map</a>). Yellow fever vaccination should be considered for all students participating in UCEAP programs in Brazil.</td>
</tr>
<tr>
<td>4/21/2017</td>
<td>Japan</td>
<td>14</td>
<td>Wording was changed to clarify when health forms must be completed. The following line was deleted: “All tests on the host university form are required and must be done within three months of application to the university.” This instruction is inconsistent with instructions provided on some of the health forms. Also, wording was added to clarify that ICU requires health forms for students in fall, year and spring programs. Summer ICU participants do not have the requirement.</td>
</tr>
</tbody>
</table>
2017 Annual Update of UCEAP Program-Specific Health Requirements

April 21, 2017 – SUPERSEDES ALL PRIOR UPDATES

This document includes new information and serves as a reminder of specific protocols.

- Refer to the electronic version of this document for the most updated information. Updates will be announced by email whenever the electronic version is modified.

- **Need supplies?** If you need **Health Clearance** forms, email HSER@eap.ucop.edu and indicate the number of forms that you need.

Summary of Changes from Previous Year

<table>
<thead>
<tr>
<th>Multi-city</th>
<th>Multi-city program <em>Landscapes of Empire, Religion &amp; Culture: Rome &amp; Istanbul</em> was replaced by a program that is only in Italy, and so falls within country requirements for ‘Italy.’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turkey</td>
<td>UCEAP programming in Turkey is suspended until further notice.</td>
</tr>
<tr>
<td>China</td>
<td><strong>Critical note:</strong> Mental health treatment is extremely difficult to obtain.</td>
</tr>
<tr>
<td>Japan</td>
<td>Tohoku Univ. no longer requires a health form.</td>
</tr>
<tr>
<td></td>
<td>Clarification was added regarding accepted medical tests for verifying immunization and TB status.</td>
</tr>
<tr>
<td>Confidential Health History forms</td>
<td>IHS&amp;ER no longer distributes multiple-part Confidential Health History forms. Students who will see a private physician for their Health Clearance should print the form from the web at <a href="http://www.eap.ucop.edu/Documents/HealthClearance/CONFIDENTIAL_Health_history_form.pdf">http://www.eap.ucop.edu/Documents/HealthClearance/CONFIDENTIAL_Health_history_form.pdf</a></td>
</tr>
</tbody>
</table>
| Health Clearance forms | The multiple-part Health Clearance forms provided by the IHS&ER Unit to Student Health Services will no longer include an instructions sheet. It is also now a duplicate form, instead of triplicate.  
  
  Private health providers and SHS centers that continue to use the multi-part form should keep a copy for the student’s file and return the original to the student to forward to UCEAP (or submit to UCEAP as per campus protocols).  
  
  Many SHS now provide the student with a screen print of a template from the PnC system that replicates the Health Clearance form. For sample PnC templates in use, see pages 35 – 37. Contact the IHS&ER unit if your SHS center is considering this change. |
UCEAP Confidential Health History Form (See Appendix for sample)
Most UC campus Student Health Service (SHS) centers use online patient portals to collect each student’s confidential health history before their health clearance is reviewed.

If your office continues to use the paper UCEAP CONFIDENTIAL HEALTH HISTORY form in some or all instances, direct students to download the form from the UCEAP website, print it and fill it out before their appointment. [http://www.eap.ucop.edu/Documents/HealthClearance/CONFIDENTIAL_Health_history_Form.pdf](http://www.eap.ucop.edu/Documents/HealthClearance/CONFIDENTIAL_Health_history_Form.pdf)

All information provided by the student on the UCEAP Confidential Health History form will be important when making a determination about the student’s health. In cases where an online patient portal is used, the information collected from the student should include all form fields.

- UCEAP recommends to give students a copy of the completed Confidential Health History form to take it abroad so that they have a health history available in case of an emergency.
- Students should NOT send a copy of the Confidential Health History form to the UCEAP Systemwide office.

UCEAP Health Clearance Form* (See Appendix for samples)
The University of California aims to facilitate a safe and smooth treatment transition for students currently in treatment. Please read the UCEAP HEALTH CLEARANCE form instructions carefully.

Many SHS now provide the student with a screen print of a template from the PnC system that replicates the Health Clearance form instead of using the multi-part form (see pgs. 35 - 37 for samples). When the paper UCEAP HEALTH CLEARANCE form is used, please verify the following before clearing the student and signing the form.

- The student’s name, campus and program (including Country, Term, and Host University and/or Program Name) should be filled in to facilitate correct routing at UCEAP.
- Signatures, contact information, and the clearance decision of all health providers who are treating the student must appear on the form and be legible. Additional forms, or signed letters on official letterhead, can be attached if the student is being treated by multiple specialists.
- Both pages of the duplicate form must be legible.

Incomplete or incorrectly completed forms may be returned to the clearing practitioner or student.

Keep a COPY for your files and return the original to the student (or submit to UCEAP as per your campus instructions).

*FYI: See Pg. 81 for a sample of the Health Clearance form used for the USA-Natural Reserve System program.

Limited Authorization Form – Optional (See Appendix for sample)
Some UC campus Student Health Service (SHS) ask some or all students participating in UCEAP programs to sign a limited authorization to disclose health information to UCEAP.

Program-Specific Medical Tests and Health Recommendations
Some programs require medical tests and/or have special health recommendations. These requirements and recommendations are indicated in the country-specific section of this document.

Refer to the electronic version of this document during the year for the most updated information. We will send e-mail updates whenever the electronic version is modified.

Program-specific forms provided in the Appendix are samples only. The UCEAP Systemwide office will send specific instructions and official forms to students, who are instructed to bring them to their appointment.
UCEAP Online Travel Course (OTC)

UCEAP continues to use the Online Travel Course (OTC), which includes health and safety information. Students in programs requiring the OTC will receive instructions to access and complete the online course as part of their UCEAP Pre-departure Checklist (PDC).

Students participating in UCEAP programs in the following countries are required to complete the OTC: Argentina, Barbados, Botswana, Brazil, China, Costa Rica, Dominican Republic, Ghana, India, Jordan, Mexico, Morocco, Russia, Senegal, Solomon Islands, South Africa, Tanzania, and Thailand.

Students are no longer required to mail a printed completion certificate to the UCEAP Systemwide office.

Recommended Discussion Topics for In-person Health Clearance (or Travel Clinic) Appointments Based on UCEAP Student Incident Data

The UCEAP International Health, Safety & Emergency Response unit coordinates, manages and tracks student incidents and cases abroad. Based on trends, we know that some students do not follow recommended treatment plans or maintain adequate health management while on UCEAP programs.

Consider discussing the following topics with the student based on their destination(s) and specific UCEAP program/activities:

- Recommendation to get all necessary vaccinations through campus or private insurance. UCEAP travel insurance does not cover vaccinations, physical exams, or other preventive care.
- Medication management (see below)
- Alcohol and drug use (see below)
- Psychological health (see below)
- Physical, psychological or learning disabilities (see below)
- The importance of identifying support systems, including UCEAP and campus staff and resources before departure
- Recommendation to make a travel clinic appointment

Strongly Recommended Vaccinations

- **Seasonal Flu:** Influenza is one of the most common ailments for UCEAP students. Students are frequently in crowded places and regularly take crowded public transportation. The UCEAP Physician Consultant recommends flu vaccination for all students, and strongly recommends it for:
  - Those who will be abroad during the fall or winter
  - Those with any chronic medical condition
- **Bacterial Meningitis:** Students planning to live in dormitories should be vaccinated against Meningococcal disease.
- **Measles** remains a common disease in many parts of the world, including Europe, the Middle East, Asia, the Pacific, and Africa. Students who have not been vaccinated are at risk of getting the disease and spreading it to others.

  *FYI:* The UCEAP insurance does not cover vaccinations, but the UC or campus SHIP and/or student’s private insurance may.

UCEAP Travel Insurance

All students will be automatically covered by UCEAP travel insurance while abroad. Here are some key facts about this coverage (see Appendix for additional information):
• Benefits start **14 days before** the official start of the student’s UCEAP program and end **31 days after** the official end of the student’s UCEAP program.

• The UCEAP insurance does **not cover preventive care**, including vaccinations and physical exams.

• The UCEAP insurance will reimburse students for **malaria prophylaxis** if it is prescribed by a doctor and filled, picked up, and paid for within the term of coverage (i.e. no more than 14 days before the official start-date of the UCEAP program). **However, if the student is covered by UC or campus SHIP, they should consider whether it is in their interest to utilize that plan and avoid the requirement to pay up front and submit a reimbursement request.**

• **Prescription medications** are covered if they are filled, picked up, and paid for within the term of coverage and are medically necessary, subject to all other policy limitations and exclusions.

• Students **pay upfront** and submit a claim for reimbursement for eligible medical services and prescription medications.

Students can be directed to the ‘Insurance’ tab of their Pre-departure Checklist (PDC) for additional information about the UCEAP travel insurance. Questions can also be sent to the UCEAP Insurance Liaison (uceapinsurance@eap.ucop.edu).

**Important Information about Medication and Allergy Management UCEAP Shares with Students Before Departure**

**Allergies:** UCEAP advises students with certain medical conditions to wear a medical alert ID bracelet or pendant at all times while abroad. Such conditions may include diabetes; asthma; serious (anaphylactic) allergies; or any condition that could have severe consequences if they are unable to communicate during a health emergency.

**Prescription Medications:**

• Although medications in amounts clearly related to personal use for the expected duration of a trip (30 days) are rarely inspected or questioned, local Customs officials can be suspicious of medications, particularly if students are traveling with large amounts. In some countries, drugs that are legal and readily available in the U.S. are considered illegal, require a prescription, or arouse the suspicions of local officials, customs and immigration authorities.

• Remind students that prescribed medication regimens are important to their health and well-being and that they should never abruptly discontinue their medication, especially abroad.

• UCEAP cannot maintain a list of prescribed (or over-the-counter) medications and their legality in the different countries. It is the student’s responsibility to get this information before departure.

• Students must:
  o Keep medicines in their original, labeled, pharmacy packaging when possible. The label should include the student’s name.
  o Obtain and carry a letter from the prescribing physician on letterhead, appropriately signed and dated, stating diagnosis, treatment, and medication regimen, including the generic name.
  o Review medication regulations on the INCB website and official government sites if they take medications containing controlled substances (including amphetamine-based medications). Excerpted national statutes for most countries can be found at [http://www.incb.org/incb/en/psychotropic-substances/travellers_country_regulations.html](http://www.incb.org/incb/en/psychotropic-substances/travellers_country_regulations.html). Also, refer students to their Program Guide.
  o Students with diabetes and those who use injectable medications should obtain and carry at all times a doctor’s letter explaining the need to carry needles and syringes.

**FYI:** According to some students’ reports, their U.S. health practitioners have assumed that doctors abroad can prescribe the same medications commonly prescribed in the U.S. This is not always the case. Students should research whether their medications are legal and locally available in their program country.
About Mailing Medications Abroad:

- Many countries have strict laws about mailing medications. Students, and their parents, have found out the hard way that their medications, including oral contraceptives and vitamins, are stopped by host country’s customs officials. Additionally, the U.S. Post Office restricts using the U.S. postal system to mail medications. Prescription medications can only be mailed by Drug Enforcement Administration (DEA) registered entities. Similar regulations may apply to over-the-counter medications.

- Do not advise students to mail any type of pharmaceuticals to other countries.

Alcohol and Drugs

**IMPORTANT:** Alcohol and drug use has had significant impacts on UCEAP students including arrest, hospitalization, victimization, eviction, disciplinary actions, and academic consequences. Ask students directly about their alcohol and drug use patterns to detect at-risk or problem drinkers so you can advise them appropriately.

Students will be subject to the laws of their host country regarding possession and consumption of alcohol, marijuana, narcotics, prescription medications, and other illegal substances. In some countries alcohol is limited or outlawed because of religious practices. In other countries alcohol is readily available, and the alcohol content may be higher than in the U.S.

UCEAP follows University of California substance abuse policies while students are abroad. Students who violate UCEAP’s substance abuse policy may be dismissed.

Psychological Health

- Pay special attention to any emotional or psychological issues that are disclosed by the student, or that are indicated by clinic notes or medications the student is taking. Preexisting emotional difficulties are often intensified by the stress of living in a foreign culture.

- Decompensation is a serious health and safety concern abroad that has the potential to create reputational and legal liability for the University as well as academic and financial consequences for the student.

- Not all countries have mental health support services or treatment facilities similar to those in the U.S. We have found that students who need continued treatment or other specific support have greater success abroad when they have a written treatment plan in place prior to departure. Consider creating a health and safety plan with the student wherein the student agrees to find appropriate resources abroad and establish sufficient support systems before departure. Contact Inés DeRomafia (ideromana@eap.ucop.edu) at the UCEAP Systemwide office for consultation or for a sample plan.

- Advise students to communicate with UCEAP before departure so their International Program Specialist can work with the student to arrange appropriate treatment and reasonable accommodations abroad.

**NOTE:** Confidential information that the student relays to UCEAP remains confidential and will be shared with UCEAP officials only on a ‘need to know’ basis. The information will only be disclosed to those in a position to help.

- Consider asking students who have a history of substance abuse and/or psychological health issues to complete and sign the UCEAP Limited Authorization for Use or Disclosure of Health Information. This will help UCEAP, UC Student Health Services, and the host university student services to work together, particularly during an emergency. You can find a sample in the Appendix.

FYI: Many UCEAP Study Centers and partners abroad maintain lists of English-speaking mental health counselors. Students often get this information during on-site orientation. They can always contact their UCEAP Representative abroad to get recommendations and assistance.
**Students with Disabilities**

- Students should register with the campus disability office before departure, even if they believe that they will not need accommodations abroad. Accommodations requested after departure cannot be facilitated by UCEAP if the campus Disability Office can’t provide an accommodations letter.

- Students must provide the UCEAP International Program Specialist with an accommodations letter from the campus Disability Office.

- Students should carry with them medical documentation of their disability and a copy of the accommodations letter from their campus disability advisor.

- Some host institutions will require medical documentation and diagnosis directly from the student to provide accommodations. Other host institutions may not be able to provide certain accommodations.

- UCEAP does not fund accommodations abroad.

**Environmental challenges and cultural attitudes towards people with disabilities:**

Advise students to:

- expect differences and to be flexible,

- research attitudes that are prevalent in their destination about people with disabilities, and

- talk with others about potential challenges and support systems they will use if those challenges materialize during their study abroad experience. For more information, refer the student to the UCEAP website, Students with Disabilities portal.
## COUNTRY AND HOST UNIVERSITY HEALTH REQUIREMENTS

<table>
<thead>
<tr>
<th>Country</th>
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<tr>
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<td>India</td>
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<td>Germany</td>
<td>Multi-City (Florence/ Barcelona)</td>
<td>USA – Natural Reserve System</td>
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<td>Hong Kong (S.A.R.)</td>
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Click this arrow in any country header to return to this page. [Hint – You must click on the actual symbol and not the gray message box that pops up when scrolling over the symbol.]

## COUNTRY AND HOST UNIVERSITY SAMPLE HEALTH FORMS

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<th>Country</th>
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<td>Taiwan</td>
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<tr>
<td>Japan – Doshisha</td>
<td>Tanzania</td>
<td></td>
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<tr>
<td>Japan – Hitotsubashi</td>
<td>USA – Natural Reserve System</td>
<td></td>
</tr>
</tbody>
</table>
ARGENTINA

Required by Government: -0-  
Required by Host University: -0-  
Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT INFORMATION ABOUT THE PROGRAM: Many program students participate in an optional field trip to Iguazu Falls in the subtropical Argentine province of Misiones (far northeastern corner of the country).

AUSTRALIA

Required by Government:

When applying for the mandatory student visa—an electronic application process—some students, depending on their length of stay and other factors, will be required by the Australian Department of Immigration to undergo a medical exam and chest X-ray. In such cases, the Australian embassy will give students instructions to download the specific and required medical forms needed for submission. These forms must be completed by a physician and returned to the Australian embassy in Washington, D.C.

Required by Host University: -0-

BARBADOS

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: Univ. of the West Indies Confidential Medical Questionnaire (see Appendix).

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

BOTSWANA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by CIEE: -0- The CIEE Physician’s Medical Report is not required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Malaria prophylactic pills—all students must sign a Malaria Prophylaxis Participation Agreement (see Appendix) and purchase antimalarials before leaving the U.S. (See Pg. 4 ‘UCEAP Travel Insurance’ for coverage details that apply to antimalarial medication.)
2. Successful completion of the UCEAP Online Travel Course (OTC).
3. IMPORTANT – MALARIA: Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.

BRAZIL

Required by Government: -0-  
Required by Host University: -0-  
Required by CIEE: -0- The CIEE Physician’s Medical Report is not required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC)

Continued on next page.
IMPORTANT INFORMATION ABOUT THE PROGRAM: Discuss with students any relevant health risks associated with attendance at large-scale events. Many students will attend Carnival (Feb. 24–28).

IMPORTANT INFORMATION ABOUT YELLOW FEVER RISK: On April 4th, the WHO once again expanded the geographic area for which YF vaccination is recommended in Brazil. It now includes all areas of Rio de Janeiro and Bahia state including urban areas (revised map). Yellow fever vaccination should be considered for all students participating in UCEAP programs in Brazil.

CANADA

Required by Government: -0-

Required by Host University: -0-

CHILE

Required by Government:

Chile has two consulates in California, located in San Francisco and Los Angeles. Students must apply for their visa at the consulate closest to their UC campus. The consulates have different health clearance timing requirements, as follows:

- The consulate in Los Angeles requires that the health clearance be completed and signed 30 days or fewer before the visa application.
- The consulate in San Francisco requires that the health clearance be completed within six months of the visa application. Despite this flexibility, UCEAP recommends that the clearance be done within three months of the visa appointment.

Both Chilean consulates require:

- The original, manually-completed, triplicate UCEAP Health Clearance form (see Appendix for sample form) signed by an MD whether an FNP, NP or PA performs the clearance.
  - The doctor's name and title must be clearly and carefully printed on the form, along with contact information including phone number, address and e-mail address.
  - The form must bear the official stamp of the medical facility for each physician signing the form. A validation stamp or business card will suffice.

Forms that do not conform to this requirement will be returned, which will delay the visa process.

Required by Host University: -0-

IMPORTANT – AIR POLLUTION: Santiago can have severe air pollution, especially during the winter months of May–August. Students with emphysema, asthma, and bronchitis should prepare for increased respiratory symptoms.

CHINA, PRC

Required by Government for all programs in China:

YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Government for students who will be in China for more than six months:

- Students who will be in China for more than six months are required to apply to extend their residency within 30 days of their arrival in China. This includes students in the Peking University (PKU) Spring+Summer Internship, Peking University (PKU) Year, and some students in back-to-back programs at different Chinese universities.

NOTE: If a student is participating in back-to-back programs in China, they should contact UCEAP International Program Specialist May Pothongsunun at (805) 893-6152 or mpothongsunun@eap.ucop.edu to find out if their program combination will exceed six months and whether or not they will need to complete the Physical Examination Record for Foreigner.

Continued on next page
• A thoroughly completed and properly stamped Physical Examination Record for Foreigner (see Appendix for notated sample form) must be submitted with the residency extension application.

• Each student required to apply for extension of residency has the option to complete the physical exam and the required lab work in the U.S. as part of the UCEAP Health Clearance process – or – to wait until after arrival in Beijing. Factors for the student to consider include:
  o Time frame: The exam and lab tests must be completed no more than six months prior to the student's registration date in China; otherwise, it will be considered invalid.
  o Potential costs associated with the exam: Students will pay approx. $70 (U.S.) to have the exam done in Beijing. Students who have the exam done in the U.S. will pay the exam cost in the U.S. (varies by physician and insurance) plus an additional $10 (U.S.) to have the results verified by the Beijing Physical Exam Facility, operated by the National Quarantine Bureau. If the form and lab results are not accepted for any reason (this can be arbitrary), the student will pay to have the exam re-done.
  o Potential costs associated with the exam results: Students who return positive test results for diseases listed on the form may not be granted a residency extension and may be required to leave China.

Use the following instructions and the notated sample form in the Appendix if a student requests to have the physical exam done at Student Health Services (SHS):

PHYSICAL EXAMINATION RECORD FOR FOREIGNERS - INSTRUCTIONS:

1. Students must use the form provided to them by UCEAP (See Appendix for notated sample form).

2. Complete all boxes; do not leave any section blank.

3. All original lab exam results attached to the form (e.g. blood tests, X-rays, etc.) must be clear and specific and bear the official* stamp of the laboratory completing the exam. Do not submit lab results marked, “COPY.” Students will be required to retake tests if lab results are illegible or improperly stamped.

   *If no other stamp is available, use an address stamp that includes the name of the UC SHS or lab.

4. Follow detailed instructions on notated sample form (see Appendix).

5. Use metric measurement units where indicated.

6. If health indicators listed on the bottom half of Pg. 1 (e.g. development, nourishment, skin, nose) are within normal ranges, write “normal” in each box.

PAGE 1

7. If test results are negative, write “negative.”

8. Write Chest X-ray results in the box indicated and attach the original, stamped lab report. Original X-ray films are not required.

9. Attach original TB lab results (stamped by UC SHS or lab). Students with active TB will not be allowed into China.
   - A positive TB skin test requires negative chest X-ray results.
   - Original chest X-ray films are not required, but a printed report is required.

10. Write ECG results in the box indicated and attach the original printout results (stamped by UC SHS or lab).

11. Clearly label and write test results for HIV and Syphilis in the box indicated.
   - The original blood test reports must be included for both AIDS and Syphilis. The Chinese government will not accept a photocopy of the HIV test result.
   - All results must be clearly marked as negative, or another health exam may be required.

12. Write “None found” in the box labeled “None of the following diseases or disorders found during the present examination” unless evidence of one of the listed diseases was, in fact, found.

Continued on next page
13. Write “None” if you have no suggestions for the student.

14. Sign and date where indicated.

15. Stamp both pages of the Physical Examination Record for Foreigner with the official stamp of the UC SHS or private physician completing the form:
   - on the student’s photo on Pg. 1, and
   - near the physician’s signature on Pg. 2.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – AIR POLLUTION: Air quality is frequently unhealthy. An increase in air pollution, which may vary due to wind patterns, is common in all major cities during winter as a result of burning soft coal for heat. People with lung disease and those at extremes of age should avoid prolonged or heavy outdoor exertion. All others should reduce prolonged or heavy outdoor exertion.

IMPORTANT – LACK OF MENTAL HEALTH TREATMENT: The prevalence of mental illness is rising in China but treatment facilities remain underdeveloped. China’s mental health care trails behind many countries around the world. There is lack of trained mental health professionals, low investment in mental health, high stigma among the population, and lack of effective public mental health systems of care. Official policy does not permit primary health care professionals to independently diagnose and treat mental disorders within the primary care system. There is a reluctance to address mental illness and psychiatry due to the limited extent to which health care professionals and public health officials are involved with the issue. The country's public health system is struggling to keep up with the demand in mental health care.

In most regions of China, few good options exist even for local families that try to find professional help. China’s mental health hospitals are too few and grossly understaffed. China has a severe undersupply of trained mental health staff. Students with pre-existing conditions will need a treatment plan in place indicating when and to whom they will reach out for help.

COSTA RICA

Tropical Biology Programs (Monteverde Fall and Spring)

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT INFORMATION ABOUT THE PROGRAM

- Students must be prepared mentally and physically for a fairly stressful 11 weeks.
- Students will spend 11 weeks in tropical rain forest, dry forest, and coastal areas. The program includes strenuous outdoor activities (e.g., camping, hiking, snorkeling, and backpacking through mountainous tropical forests). Individual research projects involve forests, fields, ocean, streams, animals or insects, and take place during the day and night.
- The academic and research work and study field trips in remote locations are demanding.
- Students camp, receive instruction outdoors and live in close quarters in biological field stations.
- Group dynamics are extremely important. Students must be able to manage well within a group.
- Access to medical attention: Although reliable medical services are available throughout Costa Rica and its outlying provinces, students will be living in a rural, tropical environment. Some program activities occur in remote places. The remote locations may be many days from medical facilities. Communication and

Continued on next page.
COSTA RICA - continued

transportation are difficult and evacuations and medical care may be significantly delayed. Examples of transportation to medical facilities: 1) About 30 minutes by boat, and another 30 minutes by car. Student could be stabilized there and, if necessary, transported to a major hospital near San Jose by car or by plane/helicopter. 2) Student would walk, get taken out by horseback or carried on a rescue board to the Monteverde Cloud Forest Reserve (14 km - at best 3 hours or so by horse). From there, student would be taken to a clinic in Monteverde (10 minutes), evaluated, treated, stabilized and possibly evacuated to San Jose (3.5 hours).

CZECH REPUBLIC

Required by Government: -0-  
Required by Host University: -0-

Required by CIEE: -0- The CIEE Physician's Medical Report is not required for students studying in CIEE programs through UCEAP.

DENMARK

Required by Government: -0-  
Required by Host University: -0-

DOMINICAN REPUBLIC

Required by Government: -0-  
Required by Host University: -0-

Required by CIEE: -0- The CIEE Physician's Medical Report is not required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:
1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT INFORMATION ABOUT THE PROGRAM: Students will spend six weeks in Santiago followed by one week in a rural community, where Malaria transmission rates may be higher.

FRANCE

Required by Government: A medical exam is given after arrival in France for the purpose of the residence permit for students with semester- or year-long visas. The exam is non-invasive (no blood work), but includes an X-ray to screen for TB.

Required by Host University: -0-

GERMANY

Required by Government: -0-  
Required by Host University: -0-

GHANA

Required by Government: YFI required for students arriving from all countries. The International Certificate of Vaccination should be affixed to the visa inside of the student's passport and presented at the port of entry in Ghana.

Required by Host University: Malaria prophylaxis pills—all students must sign a Malaria Prophylaxis Participation Agreement (see Appendix) and purchase antimalarials before leaving the U.S.

Required by UCEAP and the UCEAP Physician Consultant:
1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – MALARIA: Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.

Continued on next page.
IMPORTANT – SUN SAFETY: The sun intensity is strong in Ghana; sun block is recommended throughout the year, even if traveling during their winter months. In summer, a hat and sunglasses are strongly recommended.

IMPORTANT INFORMATION ABOUT THE PROGRAM
- Most programs in Ghana have a long duration (greater than three months). The exception is the new Summer program, which runs approximately six weeks.
- Students participate in community service and volunteer opportunities at nongovernmental organizations and schools, including the University Hospital.

HONG KONG

Required by Government: -0-

Required by Host University:

The CUHK health form is completed by the student and does not require special medical tests or physician signatures. CUHK will include the official form in their admission packet (see Appendix for sample form).

HKU and HKUST have no university health forms.

IMPORTANT INFORMATION ABOUT THE PROGRAM: The HKU summer program includes a required two week field trip to Shanghai, China.

INDIA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host Universities: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – AIR POLLUTION: Air pollution is a significant problem in many cities in India, including New Delhi and Mumbai. Students with a history of emphysema, asthma and chronic bronchitis should prepare for an increase in respiratory symptoms.

IRELAND

Required by Government: -0-

Required by Host University: -0-

ISRAEL

Required by Government: -0-

Required by Host University:

Ben-Gurion University: Complete physical examination. BGU Overseas Student Program Medical Form must be completed (see Appendix).

Hebrew University: Complete physical examination. Hebrew University Report of Medical Examination must be completed and results of any lab work noted on the form (see Appendix).

Israel Institute of Technology, Technion/Neubauer: Student must complete the Student Health Declaration Form (see Appendix). This form does not have to be signed by a medical practitioner.

ITALY

Required by Government: -0-

Required by Host University: -0-
JAPAN

Required by Government: -0-

Required by Host University: Certain host universities require a health form (see Appendix for samples).

All tests on the host university form are required and must be done within three months of application to the university.

Japanese health form required for:

- Doshisha University
- Hitotsubashi University
- International Christian University (ICU) academic year, fall/year/spring only
- Keio University

Japanese health form not required:

- Meiji Gakuin University
- Osaka University
- Tsuru University
- Waseda University
- University of Tokyo
- Tohoku University

Frequently asked questions:

1. Will ICU accept titer results for vaccination proof? **YES**
2. ICU requires either a negative tuberculin skin test or a negative CXR. Would a negative Quantiferon Gold test (the relatively new blood test for tuberculosis that rules out false positive skin tests) also be acceptable? **Yes, a NEGATIVE Quantiferon Gold Test is acceptable**
3. Is the ICU Health Form required for students participating in the new summer program at ICU? **NO**, it is only required for academic-year students in fall, year or spring programs.

IMPORTANT – MEDICATION: Japan has strict rules and stiff penalties regarding importation of prescription medications. The "Yakkan Shoumei" Certificate is required. Students are advised to determine if their medication is legal in Japan by checking the US Embassy in Japan website for more information, or by contacting the local Japanese Consulate.

http://www.mhlw.go.jp/english/policy/health-medical/pharmaceuticals/01.html

IMPORTANT – MENTAL HEALTH: No psychological services available in English in the city of Tsuru as of May 2016. The nearest English-language counseling resources are in Tokyo, which is a 3-hour round trip train ride.

JORDAN

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by CIEE: -0- The CIEE Physician’s Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

KOREA

Required by Government: -0- Required by Host University: -0-

Required by Host University Housing: TB test results on a medical report. Students must submit the test results upon arrival in order to check into the dorm. The test must be done within 2 months of the dorm move-in date. There is no actual form. **This is only applicable to students who will reside in SK Global House or International House.**

**NOTE:** Students who will reside at SK Global House or International House will need to make a separate appointment to obtain a TB test results within 60 days of the dorm move in date.
MEXICO

Required by Government:

Students who are required to apply for a visa from the Mexican Consulate (year students and some non-US citizens) may ask for a statement of good health. This can be a photocopy of the signed UCEAP Health Clearance form, or a signed letter on official letterhead stating that the student is in good health.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – AIR POLLUTION: Air pollution in Mexico City is a severe environmental problem. Acute respiratory infections are a common cause of illness in Mexico and are aggravated by Mexico’s air pollution.

MOROCCO

Required by Government: -0-  Required by Host University: -0-

Required by CIEE: -0- The CIEE Physician’s Medical Report is not required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – CLIMATE AND RESPIRATORY CONDITIONS: The UCEAP program is located in Rabat and only offered during the fall semester, which starts in early September. Rabat is hot and humid during the summer (July through September). Morocco’s climate varies by region, becoming more extreme in the interior. Desert climate in portions of this country may aggravate respiratory conditions.

MULTI-CITY PROGRAM (European Transformations: Madrid/Rome)

Required by Government: -0-  Required by Host University: -0-

MULTI-CITY PROGRAM (Global Cities Urban Realities: London/Paris)

Required by Government: -0-  Required by Host University: -0-

MULTI-CITY PROGRAM (Leadership in Social Justice and Public Policy: Mexico City/UC Sacramento, CA)

Required by Government: -0-  Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – AIR POLLUTION: Air pollution in Mexico City is a severe environmental problem. Acute respiratory infections are a common cause of illness in Mexico and are aggravated by Mexico’s air pollution.

MULTI-CITY PROGRAM (Human Rights & Cultural Memory: Buenos Aires/Santiago)

Required by Government: -0-  Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

Select ‘Argentina’ as the country to which you are traveling.

MULTI-CITY PROGRAM (Mediterranean Food & Culture: Florence/Barcelona)

Required by Government: -0-  Required by Host University: -0-
NETHERLANDS

Required by Government: -0-  Required by Host University: -0-

**NOTE:** Students may be required to complete an 'Intent to undergo a TB test' form (see Appendix for sample) as part of the application process for a residence permit. Students are not required to get a TB test prior to arrival in the Netherlands, and U.S. citizens are generally not required to get a TB test at all. Some students may choose to get a TB test, but this is not a requirement and no physician signature is required.

NEW ZEALAND

Required by Government: -0-  Required by Host University: -0-

NORWAY

Required by Government: -0-

Required by Host University for International Summer School (ISS) participants only (at this time): For students to benefit from the mandatory ISS program health insurance, they must submit the ‘Health Certificate – ISS 2017.’

The form can be downloaded from [http://www.uio.no/english/studies/summerschool/admitted/health-insurance/pdf/health-certificate-iss-2017.pdf](http://www.uio.no/english/studies/summerschool/admitted/health-insurance/pdf/health-certificate-iss-2017.pdf). It should be completed by a medical professional using the information reported by the student on the UCEAP Confidential Health History form (or online equivalent). A physical examination is not required. The signature and stamp must be that of a physician.

RUSSIA

**Required by Government:**

To get a student visa for Russia, students must submit a negative HIV test result, taken within the previous 90 days. Results must contain the name, address and phone number of the hospital/laboratory/clinic where the test was taken. The document with the test result and their completed student visa application must be sent to Travisa by the student. Students have received instructions on how to proceed.

**Required by Host University: -0-**

**Required by CIEE:** -0- The CIEE Physician’s Medical Report is not required for students studying in CIEE programs through UCEAP.

**Required by UCEAP and the UCEAP Physician Consultant:**

1. Successful completion of the UCEAP Online Travel Course (OTC).

**IMPORTANT – HIV/AIDS:** The HIV epidemic in Eastern Europe and Central Asia continues to grow, particularly in Russia, Ukraine and Uzbekistan. 85% of people living with HIV in the region live in Russia and Ukraine. Russia also accounts for eight out of ten new HIV infections. Antiretroviral treatment (ART) coverage for the region remains inadequate (35%) (Source: AVERT.org)

SENEGAL

**Required by Government:** YFI, if arriving from or transiting through countries with YF transmission risk.

**Required by CIEE:**

1. Malaria prophylactic pills—all students must sign a Malaria Prophylaxis Participation Agreement (see Appendix) and purchase antimalarials before leaving the U.S.

2. Supplemental Medical Release for students with peanut allergy (see Appendix).

3. **NOTE**—The CIEE Physician’s Medical Report is not required for students studying in CIEE programs through UCEAP.

**Required by UCEAP and the UCEAP Physician Consultant:**

1. Successful completion of the UCEAP Online Travel Course (OTC).
IMPORTANT – SUGGESTED HEALTH ADVICE

Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.

Peanuts are the main crop of Senegal and are unavoidable. Most dishes contain them in some form, and everywhere the aroma of roasted peanuts permeates the air. Students whose allergies are severe enough to induce anaphylaxis should consider another program.

SINGAPORE

Required by Government:

1. YFI, if arriving from or transiting for more than 12 hours through countries with YF transmission risk.

2. The Medical Examination Report is required for students studying in Singapore for more than six months (i.e. academic year participants only). Students must use the official form identified by NUS. Instructions and a link to the form will be available in their NUS Registration Guide (see Appendix for sample form).
   - The Medical Examination Report is required by, and will be submitted to, the Singapore Immigration & Security Checkpoints Authority to issue certain immigration documents after arrival.
   - An HIV test and TB chest X-ray are required components of the medical examination. The original copies of the laboratory reports must be attached to the Medical Examination Report.
   - Laboratory reports must be in English and be printed on official clinic forms or letterhead. The reports must include the student’s full name and date of birth.
   - The Medical Examination Report should be completed in the U.S. no more than three months prior to the student’s NUS registration date in Singapore; otherwise, it will be considered invalid.
   - The Medical Examination Report can be completed in Singapore. The cost to complete the process at NUS is about SGD 60. However, waiting to complete the Medical Examination Report in Singapore could result in a delay with receiving the Student Pass required to participate in the program.

Required by Host University: -0-

IMPORTANT INFORMATION ABOUT THE PROGRAM: The NUS Biodiversity summer program includes a required weeklong field research trip to Pulau Tioman, a tropical island off the East coast of Malaysia.

SOLOMON ISLANDS

Pacific Island Environmental & Community Health-Australia & Solomon Islands

Required by Government: YFI, if arriving from or traveling through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

2. Malaria prophylactic pills—all students must purchase antimalarials before leaving the U.S. and take them as directed by a physician to prevent Malaria.

IMPORTANT INFORMATION ABOUT THE PROGRAM

As field activities are a major component of the program and are demanding, participants must be physically fit, able to swim, and free of serious medical conditions that would require on-going medical supervision. There is little development of infrastructure in the Solomon Islands and access to many of the field sites is via hiking/climbing. Students must be prepared to participate in long-distance walks over extremely rough, remote terrain and bush land.

Continued on next page.
Students must be prepared to swim and snorkel and will be using boats to gain access to field sites. Students must be willing to abide by the water safety regulations presented and enforced by the program supervisors.

In addition, students must be flexible, open to the local culture, and tolerant of local religious practices.

It is an obligation on all participants to take appropriate medical advice and disclose any restrictions imposed by their health that may affect their ability to participate safely in the fieldwork activities. It is inappropriate for participants with potentially life threatening medical conditions that may become active during fieldwork to participate in fieldwork at remote locations.

Students should disclose any known allergies (severe or otherwise) to any substances. Students must bring any necessary medications that they may require while on the program, particularly when out in the field for several hours e.g. Epi-pen for severe allergies; Ventilin for asthma, etc. There are no existing drug manufacturers in the country and pharmaceuticals are imported from foreign wholesalers and manufacturers in Australia, New Zealand, Japan, the United States and Singapore.

MALARIA: Help students to understand that they must protect themselves from malaria by taking antimalarials and following personal protective practices to prevent mosquito bites.

ACCESS TO MEDICAL CARE: Although limited medical services are available in the capital city of Honiara, students will be living mostly in the western islands; which are more remote and rural. Transportation between the country's many islands is mainly by ferry, outboard motorboat or canoe. There are few inter-island flights and limited roadways. Evacuations and medical care may be significantly delayed. Levels of health literacy and patient education are low among the population, and there are limited sources of information on the quality of health services. Faculty members in charge of the group will be helping students navigate the need for care.

ACCESS TO MENTAL HEALTH CARE: Primary health care facilities have the capacity to treat and refer mental health patients. However, most facilities are poorly equipped to provide support to people with mental illness.

SOUTH AFRICA

Required by Government for visa (do not submit to UCEAP):

1. Medical Certificate (form B1-811), one page (see Appendix).
2. Radiological Report (form B1-806), one page. Skin TB test is acceptable to attach in lieu of Radiological Report (chest X-ray). Either the results of a TB test or an X-ray report are required to submit to the consulate in order to obtain a student visa (see Appendix).
3. YFI, if arriving from or transiting through countries with YF transmission risk.

NOTE: Medical and TB test results (above) must not be older than 6 months at the time of visa application at the Los Angeles Consulate.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – HIV/AIDS: HIV/AIDS is estimated to be present in 18% of the adult population putting this country in the top tier of all countries. Students must understand STI concepts and risks for HIV transmission. (Source: Travax).

South Africa has the largest antiretroviral therapy program in the world, but also has the world’s largest epidemic, so access to treatment is limited.

IMPORTANT – SUN SAFETY: The sun intensity is strong in South Africa; sun block is recommended throughout the year, even if traveling during their winter months. In summer, a hat and sunglasses are strongly recommended.
SPAIN

Required by Government for students who will be in Spain for more than six months: An original medical certificate meeting the following requirements:

- It must be printed on the medical facility’s letterhead.
- It must be signed by a physician (MD or DO). Stamped signatures are not acceptable.
- It must bear the official stamp of the administering medical facility in addition to the doctor’s signature.
- It must be issued in the place of the student’s residence.
- It must contain the required text in both English and Spanish, and each version must be signed and dated by the physician.

Required text:

<table>
<thead>
<tr>
<th>This medical certificate attests that Mr. / Ms. [student’s name as it appears on their passport] does not suffer from any illness that would pose a threat to public health according to the International Health Regulations of 2005.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
</tr>
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</table>

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<tr>
<th>Este certificado médico acredita que el Sr./Sra [student’s name as it appears on their passport] no padece ninguna de las enfermedades que pueden tener repercusiones graves a la salud pública, en conformidad con lo dispuesto en el Reglamento Sanitario Internacional del 2005.</th>
</tr>
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<tbody>
<tr>
<td>Firma</td>
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</tbody>
</table>

The doctor must certify that the student does not suffer from any illness that would pose a threat to public health according to WHO IHR 2005. This includes, but is not necessarily limited to: Small pox, SARS, Human Influenza caused by a new subtype, Poliomyelitis due to wildtype poliovirus.

Visit the World Health Organization website for additional information regarding the control and containment of known risks to public health.

- Any amendment to the certificate or erasure may render it invalid.
- The certificate is valid for three months from the issue date.

FYI: Students may be required to get a medical evaluation after arrival in Spain for visa renewal.

Required by Host University: -0-

SWEDEN

Required by Government: -0- Required by Host University: -0-

SWITZERLAND

Required by Government: -0- Required by Host University: -0-

TAIWAN

Required by Government: Year students ONLY will submit a supplemental health certificate (see Appendix) with their residence visa application. They are advised to do this after their arrival.

Required by Host University:

- National Taiwan Normal University (All): -0-
- National Taiwan University (Summer): -0-
- National Taiwan University (Fall/Year/Spring): Incoming Exchange/Visiting Students Health Exam Form and Medical Examination Requirements for Students Applying for Short-Term Study in Taiwan (Form C), including chest X-ray results (see Appendix).

Continued on next page.
Form C lists the medical examination requirements for students applying for study in Taiwan. Students must provide information such as, the name of the vaccine, the date of the immunization, the name of the hospital or clinic, and the signature of the physician administering the vaccine, to the physician who fills in this form. If the student does not have measles or mumps IgG antibodies, at least one dose of MMR immunization is indicated to meet the medical examination requirements.

Refer to the notated sample forms in the appendix.

Students must submit the form online to the NTU Office of International Affairs and in person at the on-site registration.

The physical exam must be completed, and form signed by a healthcare professional, no more than three months prior to their registration at NTU. Physical exam timeframe guidelines:

- The health exam must be done in July/August/September for Fall and Year programs.
- The health exam must be done in December/January/February for the Spring program.

Chest X-ray films do not need to be submitted to UCEAP or the host university.

TANZANIA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by CIEE: Malaria prophylactic pills—all students must sign a Malaria Prophylaxis Participation Agreement (see Appendix) and purchase antimalarials before leaving the U.S.

NOTE—The CIEE Physician’s Medical Report is not required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – MALARIA: Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.

THAILAND

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Recommended by Host University for students in the Public Health summer program:

Malaria prophylactic pills—it is recommended that students purchase antimalarials before leaving the U.S.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Online Travel Course (OTC).

IMPORTANT – SUGGESTED HEALTH ADVICE

- Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.
- Bangkok has poor air quality, had the worse dengue epidemic in 20 years in 2013, and has a high incidence of rabies. Advise accordingly.
- Warn students to avoid places such as poultry farms and bird markets where live poultry is raised or kept, and avoid contact with sick or dead poultry.
- Thailand now has the highest number of officially reported AIDS cases in Southeast Asia. Talk to students about unsafe sex, unsterile medical/dental facilities, shared needles, and unnecessary blood transfusions.
- Students with severe food allergies should be advised to take precautions, as the cuisine commonly includes ingredients that can cause anaphylaxis in those affected.

IMPORTANT INFORMATION ABOUT THE PROGRAM: The summer programs include required field trips to other regions of Thailand.
UNITED KINGDOM

Required by Government: -0-  Required by Host University: -0-

NOTE: Group C meningococcal vaccination may be required after arrival by some host universities.

UNITED STATES – NATURAL RESERVE SYSTEM

Required by Government: -0-  Required by Host University: -0-

California Ecology and Conservation (Summer, Fall, Spring)

Required by UCEAP:
1. Completion of the NRS Health Forms

IMPORTANT INFORMATION ABOUT THE PROGRAM:

- The Natural Reserve System ("NRS"): California Ecology and Conservation program (the "Program") exposes students to a wide range of state ecosystems as they travel from one reserve in the UC Natural Reserve System to another.
- Students spend 7 weeks at Natural Reserves in California. Environments include mountains, desert, coastal, and island. The Program includes strenuous outdoor activities (e.g., camping and hiking)
- Research projects involve forests, fields, ocean, streams, animals or insects, and take place during the day and after dark.
- The academic and research work and study field trips in remote locations are demanding.
- Students camp, receive instruction outdoors and live in close quarters in biological field stations.
- Group dynamics are extremely important. Students must be able to manage well within a group.
- Access to medical attention: Although reliable medical services are available throughout California, students will be living in rural environments. These remote locations may be hours from medical facilities. Communication and transportation are difficult at some Natural Reserves and evacuations and medical care may be delayed.

Access to medical attention: Although reliable medical services are available throughout California, students will be living in rural environments. Some program activities occur in remote places, such as Santa Cruz Island. The remote locations may be hours from medical facilities. Communication and transportation are difficult at some Natural Reserves and evacuations and medical care may be delayed.
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Appendix

Sample UCEAP Forms

2017 Annual Health Update
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Confidential Health History Form

*** DO NOT SEND A COPY OF THIS FORM TO YOUR CAMPUS EAP OFFICE OR TO THE UCEAP SYSTEMWIDE OFFICE ***

Instructions for Students
(Read carefully and complete attached before the health clearance)

- The UCEAP Health Clearance is a requirement to participate in UCEAP. It CANNOT BE WAIVED. If you do not comply with all aspects of the UCEAP health clearance process, you may be dismissed from UCEAP.

- Complete this form accurately and truthfully before the health clearance consultation. Failure to provide complete and accurate information may be grounds for non-participation in UCEAP.

- Inform UCEAP of any recent medical or special needs and/or if any changes in health (physical, mental, dental, or if you have been prescribed new medications or a change in medication dosage) occur after the health clearance. You will be required to get a second clearance should your health history change since the date of the initial clearance. Failure to disclose changes in your health, including new illnesses, injuries, allergies, can endanger your health and may be grounds for non-participation in UCEAP.

- Disclose on this form all medical history to the health provider performing your clearance; even if you believe that a condition is under control. Your confidential disclosure will allow medical professionals to help you make arrangements or plans to facilitate your successful UCEAP experience. Identifying medical or mental health problems allows everyone involved in this process the opportunity to work with you to anticipate potential complications. We strongly encourage you to disclose so you can have a meaningful, rewarding and safe experience.

If you have a chronic medical condition, such as allergies or diabetes, prepare to manage your condition abroad. Consider how the new environment and the stresses of study abroad will affect your health. Pre-existing psychological conditions are often intensified by living in a different culture. Also, there may be fewer, or inadequate, local resources to help you manage potential triggers.

For Students Traveling with Prescription Medication

1. Make sure that it is legal abroad and that you can take a supply to last throughout your stay. Although medications in amounts clearly related to personal use are rarely inspected or questioned, customs officials can become suspicious of medications in large quantities. If intending to travel with prescription medications containing controlled substance, review medication regulations in official government sites. Check your UCEAP Program Guide for specific information. Also, addresses and excerpted national statutes for most countries can be found at the International Narcotics Control Board, www.incb.org/incb/en/psychotropic-substances/travellers_country_regulations.html.

2. Carry a letter from your physician, on letterhead, explaining your diagnosis, treatment, and prescription regimen. Carry your prescription in original containers, and keep the letter from your physician handy.

3. If you are taking a psychotropic, you must be stable on your medication. Medically stable means that you must be in a state where no changes in symptoms are foreseen or expected. Work closely with your doctor to design a treatment plan, research medication availability overseas, understand possible emotional triggers, and know how to reach out for help while abroad, if needed.

Instructions (depending on the campus)

☐ FILL OUT this form completely and honestly before your health appointment.

☐ TAKE the completed form with you to your appointment and discuss your health history with the practitioner.

☐ GIVE a copy of this form to the health practitioner who performs your clearance.

☐ TAKE a copy abroad in case of a medical emergency. Do not mail a copy to the UCEAP Systemwide Office.
UCEAP Confidential Health History Form

*** DO NOT SEND THIS CONFIDENTIAL FORM TO UCEAP ***

The UCEAP health clearance must be completed 60 days before departure (except for Chile, refer to your PDC). It is a non-waivable requirement. IF YOU ARE NOT IN COMPLIANCE, YOU MAY NOT BE APPROVED TO PARTICIPATE IN, OR MAY BE DISMISSED FROM UCEAP. Your answers below and a review of your medical & mental health records on file will be used during the health clearance process.

You must inform UCEAP of any recent medical or special needs or changes in health that occur before the start of the program.

Complete this form BEFORE your medical appointment. Failure to provide complete and accurate information may be grounds for non-participation in UCEAP. Your confidential disclosure could prevent complications during an emergency and/or help to plan better for a successful and safe experience abroad.

PRINT:
Last name __________________评 First name __________________ Middle name __________________ Sex: M □ F □
Program/Country __________________ Student I.D. __________________
Person to notify in case of emergency: NAME __________________________
ADDRESS: STREET __________________ CITY __________________ STATE, ZIP CODE __________________
DAYTIME PHONE, INCLUDE AREA CODE __________________

GENERAL HEALTH:
List any recent or continuing health problems: __________________________
List any physical or learning disabilities: __________________________
Are you currently (last 12 months) under the care of a doctor or other health care professional, including mental health treatment? □ Yes □ No
Doctor’s Name: __________________________ Phone/Fax: __________________________
Address: __________________________
For what condition(s): __________________________

SURGERIES: List type and year __________________

DRUG/FOOD ALLERGIES: List any drug or food allergies and briefly describe reaction: __________________________

MEDICAL HISTORY: Students with known and ongoing medical conditions must prepare for and manage their condition overseas. Complete below:

<table>
<thead>
<tr>
<th>Chronic headaches/migraines</th>
<th>Ulcer/collitis</th>
<th>Ulcer/collitis</th>
<th>Back/joint problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy/seizures</td>
<td>Hepatitis/gallbladder</td>
<td>Bladder/kidney problems</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Asthma/lung disease</td>
<td></td>
<td></td>
<td>Thyroid problems</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Diabetes</td>
<td></td>
<td>Recurrent or chronic infectious diseases</td>
</tr>
<tr>
<td>Anemia or bleeding disorder</td>
<td>Cancer/tumors</td>
<td></td>
<td>Other (List)</td>
</tr>
</tbody>
</table>

MENTAL HEALTH HISTORY: Have you ever been diagnosed, been treated for, or hospitalized for the following?

<table>
<thead>
<tr>
<th>Any mental health condition, including depression/anxiety</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse (alcohol or drugs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorder (anorexia/bulimia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you taking/have ever taken medication for above?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IMMUNIZATION RECORD: Indicate most recent date.

<table>
<thead>
<tr>
<th>Polio immunization</th>
<th>Measles</th>
<th>Mumps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus booster or Tetanus/diphtheria booster</td>
<td>Rubella</td>
<td>MMR</td>
</tr>
</tbody>
</table>

MEDICATIONS: Student is responsible for ensuring that all medications are legally permissible abroad

Are you currently taking any medications? □ Yes □ No Specify name, type, & brand of any medication and whether you use inhaler, bee sting kit.

SERVICES YOU WILL NEED TO FACILITATE YOUR EDUCATION (e.g., note takers)

I certify that all responses made on this form are complete, true and accurate. I understand that if there are any changes in my health status, I will contact UCEAP immediately. I understand that if I withhold information on this form I may be withdrawn from the program.

Student’s Signature: __________________________ Date: __________________________
# Health Clearance Instructions for Students

You are required to obtain a health clearance to participate in UCEAP. UCEAP and the UC campus reserve the right to require a health clearance through the campus Student Health Service. You must follow your UC campus Student Health Service procedures to get a health clearance. DO NOT DELAY. The health clearance must be completed no later than two months (60 days) before departure, except for Chile*. If you do not comply, you may be dismissed.

## HEALTH CLEARANCE REQUIRED FROM CAMPUS STUDENT HEALTH SERVICE

<table>
<thead>
<tr>
<th>Botswana</th>
<th>Ghana</th>
<th>Senegal</th>
<th>Solomon Islands</th>
<th>South Africa</th>
<th>Tanzania</th>
</tr>
</thead>
</table>

**INSTRUCTIONS:**
Your UC campus Student Health Service (SHS) must clear you to study through UCEAP. Some SHS limit the number of ‘health clearance’ appointments. Others have deadlines for submitting your Confidential Health History information. Begin this process early.

## HEALTH CLEARANCE REQUIRED FROM CAMPUS SHS – OR – PRIVATE PHYSICIAN

| Argentina | Australia | Barbados | Brazil | Canada | Chile | China | Costa Rica | Czech Republic | Denmark | Dominican Republic | France | Germany | Hong Kong | Ireland | Israel | Italy | Japan | Jordan | Korea | Mexico | Morocco | Multi-city Programs | Netherlands | New Zealand | Norway | Russia | Singapore | Spain | Sweden | Switzerland | Taiwan | Thailand | UK |
|-----------|-----------|----------|--------|--------|-------|-------|------------|----------------|---------|-------------------|--------|---------|-----------|---------|--------|-------|-------|--------|-------|--------|----------|--------|----------|---------|--------|---------|---------|--------|----------|---------|

**INSTRUCTIONS:**
Obtain a health clearance either from your UC campus Student Health Service (SHS) or from a private physician, according to campus-specific protocols. For a campus SHS health clearance follow all instructions provided by the campus EAP or SHS office. **UCEAP and/or the campus reserve the right to require the clearance through the campus Student Health Service.** If you decide to use a private physician, instructions are on the following page.

Complete the process by stipulated deadlines, but no later than two months (60 days) before departure*.

* **Chile:** If you will apply for the visa at Los Angeles Consulate of Chile, you must submit a health clearance that is dated 30 days, or less, before the application date of your visa. The Consulate of Chile located in San Francisco does not have this requirement.

## ONLINE TRAVEL COURSE (OTC)

<table>
<thead>
<tr>
<th>Argentina</th>
<th>Barbados</th>
<th>Botswana</th>
<th>Brazil</th>
<th>China</th>
<th>Costa Rica</th>
<th>Dominican Rep.</th>
<th>Ghana</th>
<th>India</th>
<th>Jordan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexico</td>
<td>Morocco</td>
<td>Russia</td>
<td>Senegal</td>
<td>Solomon Islands</td>
<td>South Africa</td>
<td>Tanzania</td>
<td>Thailand</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**This course does not replace an in-person appointment with a travel health specialist for necessary travel medications and immunizations.**

**INSTRUCTIONS:**
Complete the UCEAP Online Travel Course (OTC) according to instructions in the Pre-Departure Checklist for your program. The OTC covers critical information about:

- vaccine-preventable diseases,
- personal protective measures against insect bites,
- food and water safety,
- travel with medication,
- personal safety precautions, etc.

After you complete the course, make an appointment with a travel health specialist at the campus SHS—or—a private travel health specialist. Only medical professionals can provide advice about vaccinations and medications.
HEALTH CLEARANCE THROUGH A PRIVATE PHYSICIAN

1. Make appointments with your personal doctor and specialist(s) *only if your UCEAP destination and campus allow clearances from outside practitioners*. Specialist clearances should be done BEFORE the general practitioner clearance.

2. Pick up blank **Confidential Health History** and **UCEAP Health Clearance** forms from your campus UCEAP advisor –OR– access them online, according to campus protocols.
   a. Complete the **Confidential Health History** form clearly and accurately **before each appointment**, and SIGN it. You must provide the completed form to each doctor and specialist who will sign your clearance. Disclosing physical and mental conditions is essential so the doctor discuss a treatment plan for your time abroad.
   b. Complete the top of the **UCEAP Health Clearance** form with your name and complete program information (Country, Host Univ, Program Name, and Term).

3. Attend appointments with completed documents in hand, including any specialist clearances already received. Ask the physician to carefully follow the instructions on the front page of the **UCEAP Health Clearance Form & Instructions for Private Health Care Providers**.

AFTER THE HEALTH CLEARANCE IS COMPLETED AND SIGNED BY ALL SPECIALISTS AND THE GENERAL PRACTITIONER

1. **UCEAP Health Clearance** – Mail the original of the completed form **before the deadline** to:
   University of California Education Abroad Program
   6950 Hollister Avenue, Suite 200, Goleta, CA 93117-5823
   
   **UCEAP must receive this form at least two months before departure to prevent delays in participation*.**
   
   *Except Chile: The Consulate of Chile in Los Angeles requires that clearances be completed and dated 30 days, or less, before your visa application date. The Consulate in San Francisco does **not** have this requirement.

2. **Confidential Health History**
   a. Leave the original, completed Confidential Health History form with your doctor for your file, if possible.
   b. Take a copy with you abroad in case you need to provide a medical history in an emergency.
   c. Do not send a copy to the UCEAP Systemwide Office.

STUDENTS WITH SPECIAL NEEDS: Students who have any disability, or other chronic systemic condition for which they will seek accommodation abroad are advised to alert the Campus EAP office immediately so staff can notify the UCEAP Systemwide Office. The UC campus Disabled Students Office must send a memo to UCEAP indicating the nature of the student’s needs. In light of varying conditions and services available, universities abroad may require this memo with sufficient notice for a request for accommodations to be fairly evaluated. The students must secure funding for the accommodation. Students who disclose needs at the last minute, or who require accommodations that cannot be made available in the host country, may be advised to postpone participation or consider another site. (NH 12/2013)
Health Clearance Form & Instructions for Private Health Care Providers

UCEAP offers programs around the world, including remote areas. The type of program can vary; some include physically demanding components. Students with pre-existing health conditions may find that treatment options and availability of Western-style health and psychological services vary greatly. A student is more likely to succeed when they disclose medical conditions, research medication and local treatment availability, and discuss the specific UCEAP academic program and its activities with all medical providers, including specialists (if applicable) so a treatment plan can be discussed.

Health care providers should review the student’s medical history and consider clearing a student for participation if:

a) Medical conditions are stabilized.

b) A treatment plan is in place for required and recommended continued care while abroad (if applicable). If there is need for continued treatment, the student must have a letter on letterhead, signed by you, indicating diagnosis, treatment and medication regimen. Otherwise, the student may risk not being able to receive continued treatment or a medication refill.

c) The student has been in therapeutic compliance, including adherence to medication (if applicable).

REQUIREMENTS

- The student must be assessed to participate in UCEAP by all specialists currently treating them in addition to a primary care physician.
- Health care providers must be licensed and cannot be an immediate family member. AMA Code of Ethics E-8.19
- Health care providers must provide legible contact information.
- The student’s name and program information must appear on the form. Blank forms are not acceptable.
- Students must submit signed health clearances to UCEAP no later than 60 days before departure (except for Chile).
- Students are expected to update UCEAP of any significant changes in health status after the date of the initial clearance and are required to submit an updated health clearance.
- UCEAP and/or UC campuses reserve the right to require the health clearance to be done through the campus Student Health Service, even if this is not a requirement of the UCEAP program.

STUDENT INSTRUCTIONS – Refer to campus health clearance instructions for campus-specific requirements

This is a mandatory requirement. Your information is confidential and only shared on a need to know basis to facilitate assistance, particularly during an emergency. Deadline: No later than 60 days before departure (except for Chile).

1. Complete the Confidential Health History form accurately. Disclose all pertinent medical information to facilitate an informed medical assessment. Depending on the nature of your condition you may need to have multiple consultations to plan for continued treatment abroad.

2. Legibly write your name, UC campus, and UCEAP program name (country, host institution or program title, and term), on the attached Health Clearance form before your appointment.

3. Confirm medication availability and treatment options in your program location. Discuss issues with your doctor who may recommend changes as appropriate.

4. After your appointment, return the completed and signed original Health Clearance form(s) by the stipulated deadline to: UCEAP Systemwide Office, 6950 Hollister Ave, Suite 200, Goleta, CA 93117-5823

5. Inform the UCEAP Systemwide Office (UCEAP) of medical needs, disability accommodations and/or changes in health that occur after the date of the initial health clearance. Failure to provide complete and accurate information may be grounds for non-participation in, or dismissal from, UCEAP.
SPECIALIST INSTRUCTIONS – For all medical specialists and/or psychotherapists treating the student

1. Ask student about the specific UCEAP academic program and related activities, medication legality, and/or treatment availability at their location. Discuss alternatives as appropriate. If medication changes are required, ensure that you have time to monitor the medication effectiveness before you clear the student to participate.

2. With the information that the student provides, assess environmental or programmatic factors that may affect chronic health conditions (allergies, asthma, anxiety, etc.) and make recommendations as appropriate.

3. Complete and sign the left section of the Health Clearance after meeting with the student, reviewing their medical history, and assessing the student to be stable and prepared to manage any medical conditions abroad.

HEALTH CARE PROVIDER INSTRUCTIONS – For all students

1. The student must present to you a completed Confidential Health History form. A physical examination is not needed unless required by the program. The student is responsible for providing this information.

2. The student must present to you signed health clearances from any specialist currently treating them.

3. Discuss/review the student’s health and immunization history referring to the Confidential Health History form completed by the student and the student’s medical records on file.

4. Ask student about medication and other treatment availability in their program location. Discuss alternatives as appropriate. If medication changes are required, ensure that you have adequate time to monitor the medication effectiveness before the student is cleared to participate in UCEAP.

5. With the information that the student provides, assess environmental or programmatic factors that may affect health conditions (allergies, asthma, etc.) and make recommendations as appropriate.

6. Complete and sign the bottom section of the Health Clearance after meeting with the student, reviewing their medical history, and assessing the student to be stable and prepared to manage any medical conditions abroad.
STUDENT: Complete top section clearly with a ball point pen before appointment.

Student First and Last Name

UC Campus

UCEAP Program Country/Countries

Program Title

Partner/Host Univ

Term

Multi-city

HEALTH CARE PROVIDERS must be licensed to practice and cannot be an immediate family member. *AMA Code of Ethics E-8.19*

Check either 1 or 2 in the appropriate box below. Only disclose information that is necessary and relevant to UCEAP’s health clearance process.

I have reviewed the student’s Confidential Health History form and medical records on file. Based on the information provided to me by the student on the health history form, a review of their medical records and specialist recommendations (if applicable), knowledge of the student’s personal health history, and knowledge of the student’s UCEAP program destination, to the best of my knowledge, the student is:

**Licensed SPECIALIST OR PSYCHOTHERAPIST**

Section & signature required if student is being treated by one.

1. □ CLEARED (Check all that apply below)
   - □ 1.a No medical or psychiatric contraindications to UCEAP participation.
   - □ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.
   - □ 1.c Student strongly advised to continue treatment abroad (e.g., counseling, medical monitoring, etc.) Indicate that student has treatment plan in place and is stable.
   - □ 1.d Student advised to find out if medication (or appropriate substitute) is locally available. Student advised to carry a sufficient supply to last through entire program (if allowed by customs). If on medication, please list.
   - □ 1.e List significant allergies (e.g., medication, food, etc.):

Complete notes on back of form if necessary.

2. □ NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Health Provider: *PRINT LEGIBLY name and title*

Signature:

Date

Phone #

**Licensed HEALTH CARE PROVIDER (MD, DO, NP, RN, or PA)**

Section & signature required for all students.

1. □ CLEARED (Check all that apply below)
   - □ 1.a No medical or psychiatric contraindications to UCEAP participation.
   - □ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.
   - □ 1.c Student strongly advised to continue treatment abroad (e.g., counseling, medical monitoring, etc.) Indicate that student has treatment plan in place and is stable.
   - □ 1.d Student advised to find out if medication (or appropriate substitute) is locally available. Student advised to carry a sufficient supply to last through entire program (if allowed by customs). If on medication, please list.
   - □ 1.e List significant allergies (e.g., medication, food, etc.):

Complete notes on back of form if necessary.

2. □ NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Health Provider: *PRINT LEGIBLY name and title*

Signature:

Date

Phone #

Upon completion, keep one copy on file and give the original to the student for mailing by the stipulated deadline to:

UCEAP, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117

2/2017
UNIVERSITY OF CALIFORNIA, EDUCATION ABROAD PROGRAM:
Health Clearance Form for Students Planning to Study Abroad

UC Campus: UCSB
EAP Program Name: University of Barcelona
Country: Spain
Host University: University of Barcelona
Term: Winter/Spring 2016

HEALTH PROVIDER: Health provider must be licensed to practice and cannot be an immediate family member (AMA Code of Ethics E-8.19). Only disclose information that is necessary and relevant to UCEAP's duties.

I have reviewed the student's Confidential Health History form, and medical records on file. Based on the information provided to me by the student on the form, a review of the student's personal health history, and knowing the student's UCEAP country destination, to the best of my knowledge, the student is:

- 1.CLEARED (Check all that apply below)
- 1a. No medical or psychiatric contraindications to UCEAP participation.

Visit Summary
Professional: ON-LINE ASSESSMENT CLEARANCE (98969)
DIAGNOSIS
Encounter for issuance of medical certificate (Z02.79)
UCSB Student Health Service - 805-893-3088
Student is cleared based on the information disclosed in the Confidential Health History and review of the Student Health medical record.

Signed by Kimberly Finegold, NP on 10/29/2015 7:42:10 AM
LAST NAME, FIRST - Pt#:__________ - DOB:_______ - Sex:____ - Age:___

10/16/2015 11:05 AM with KAY, MICHELLE NP for EAP CLEARANCE (NOT AN APPOINTMENT) TIME
Encounter #: A3078841-93 Appointment Reason: EAP Clearance

UNIVERSITY OF CALIFORNIA, EDUCATION ABROAD PROGRAM:
Health Clearance Form for Students Planning to Study Abroad

UC Campus: UC
Country: Spain
Host University : University of Barcelona
Term: Spring 2016

HEALTH PROVIDER: Health provider must be licensed to practice and cannot be an immediate family member (AMA Code of Ethics E-8.19). Only disclose the information that is necessary and relevant to UCEAP's duties.

I have reviewed the student's Confidential Health History form, and medical records on file, with the student. Based on the information provided to me by the student on the Confidential Health History form, and following a review of the student's personal health history, to the best of my knowledge, the student is:

1. CLEARED (Check all that apply below)
   1a. No medical or psychiatric contraindications to UCEAP participation.

Encounter Code
Professional: HEALTH HISTORY REVIEW ONLINE (EAP) (99420)
Diagnosis
Encounter for other administrative examinations (202.89) (EAP CLEARANCE)

Signed by Michelle Kay NP on 10/15/2015 11:31:27 AM
University of California UCEAP Health Clearance Form

Last Name, First

Patient Name

A########

UCSD SPAIN FALL 2015

HEALTH PROVIDER: Health provider must be licensed to practice and cannot be an immediate family member (ASMA Code of Ethics E-8.19). Only disclose information that is necessary and relevant to UCEAP's duties.

I have reviewed the student’s Confidential Health History form, and medical records on file. Based on the information provided to me by the student on the Confidential Health History form, a review of the student's personal health history and knowing the student’s final UCEAP country destination, to the best of my knowledge, the student is:

Licensed Psychotherapist or Licensed Specialist (Section & signature required if student is being treated for chronic health conditions.)

1. ___ CLEARED (Check all that apply below)

   __ 1.a No medical or psychiatric contraindications to UCEAP participation.

   __ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting disability and indicating who will pay for services is required.

   __ 1.c Student advised to arrange services to facilitate a healthy and safe stay abroad (e.g., regularly available psychiatric therapy, etc) indicate that student has treatment plan in place and is stable.

   __ 1.d Student advised to find out if medication (or appropriate substitute) is locally available. If not locally available, student advised to carry a sufficient supply to last through the end of the program. If on medication, please list. Indicate if significant allergy to any medication.

2. ___ Student is NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Specialist - OR - Psychotherapist (Print LEGIBLY name and title):

Phone number (include area code)

Signature: ____________________________ Date: April 23, 2015

Licensed Physician/Health Practitioner

1. __ CLEARED (Check all that apply below)

   __ 1.a No medical or psychiatric contraindications to UCEAP participation.

   __ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting disability and indicating who will pay for services is required.

   __ 1.c Student advised to arrange services to facilitate a healthy and safe stay abroad (e.g., regularly available psychiatric therapy, etc) indicate that student has treatment plan in place and is stable.

   __ 1.d Student advised to find out if medication (or appropriate substitute) is locally available. If not locally available, student advised to carry a sufficient supply to last through the end of the program. If on medication, please list. Indicate if significant allergy to any medication.

2. ___ Student is NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Physician/Health Practitioner, MD, NP, DO, PA or RN. (Print LEGIBLY name and title):

Bohn O'Meara NP

Phone number (include area code)

Signature: ____________ Date: April 23, 2015

Upon completion, the student must send the original and one copy of this form to UCEAP by the deadline. UCEAP will mail one copy to the UCEAP Study Center.

Mail to: UCEAP Systemwide Office, 6950 Hollister Ave, Suite 200, Goleta, CA 93117-5623
This page intentionally left blank.
UCEAP LIMITED AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

INSTRUCTIONS:

1. Complete all BLANK sections. SIGN and DATE the form.

2. PROVIDE A COPY of this limited authorization to each physician, health practitioner, or psychotherapist, who has seen you in the past 12 months.

3. RETURN COMPLETED, SIGNED, form to: Ines DeRomana, Health, Safety and Emergency Response, University of California System, Education Abroad Program, (UCEAP), 6950 Hollister Avenue, Suite 200, Goleta, CA 93117. Email, ideromana@eap.ucop.edu.

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

Use and Disclosure of Health Information

I, ___________________________________________ (“Student”), participating in

PRINT student’s name

UCEAP Program Name include, Country, Host University and Term

hereby authorize all physicians, all health practitioners, and all psychotherapists, who have provided care to me within the last twelve (12) months, including each person listed on the last page of this limited authorization to release to University of California Education Abroad Program Universitywide Office, c/o Inés DeRomana

the following information:

a. ☑ All health information pertaining to my medical history, mental or physical condition and treatment received — OR

☐ Only the following records or types of health information (including any dates):

b. I specifically authorize release of the following information (check as appropriate):

☑ Mental health treatment information¹

☐ HIV test results

☐ Alcohol/drug treatment information

¹ If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master’s degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.
A separate authorization is required to authorize the disclosure or use of psychotherapy notes as defined by HIPAA (45 C.F.R. section 164.501). Further, I authorize the University of California, Education Abroad Program (UCEAP) and its agents to contact my emergency contact as indicated on the emergency form, in connection with my general welfare abroad.

**Purpose**

Purpose of requested use or disclosure: **☑** patient request  **OR**  **☒** other: To obtain an UCEAP health clearance, to obtain information regarding Student’s compliance with any conditional health clearance provisions during UCEAP, for use in seeking health care for Student while abroad as part of UCEAP, and to notify the emergency contact on record at UCEAP of any health emergency Student suffers while participating in the UCEAP program.

**Expiration**

This Limited Authorization expires upon completion of Student’s participation in UCEAP.

**My Rights**

I may refuse to sign this Limited Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. However, this Limited Authorization must be signed to obtain a health clearance to participate in UCEAP.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this Limited Authorization at any time, but I must do so in writing and submit it to the following address: Inés DeRomâña, University of California Education Abroad Program Systemwide Office, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Limited Authorization.

I have a right to receive a copy of this Limited Authorization. Information disclosed pursuant to this Limited Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

A scanned copy attached to an email message, a facsimile, or a photocopy of this signed and completed Limited Authorization may be used as if it is a signed and completed original.

**Student’s Signature**

Date: ________________________ Time: ______________ am/pm

Signature: ____________________________________________

(patient/representative/spouse/financially responsible party)

---

2 If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan’s eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(d)(1), (e)(2)).
**LIST OF HEALTH PROVIDERS**

List each physician, each health practitioner, and each psychotherapist, who has provided care to Student within the last twelve (12) months:

*Please print.*

- UC Student Health Service
- UC Student Counseling Center

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
USE AND DISCLOSURE OF HEALTH INFORMATION

I acknowledge the following
I hereby authorize all physicians, all health practitioners, and all psychotherapists, who have provided care to me within the last twelve (12) months, including each person listed on this limited authorization to release to University of California Education Abroad Program University-wide office, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117 and to the Tang Center, 2222 Bancroft Way, Berkeley, CA 94720, the following information:

a. All health information pertaining to my medical history, mental or physical condition and treatment received OR
List below:
List all providers that you have seen within the past 12 months. Include Name of Provider, Specialty, Address and Phone number.

Frank Lin, M.D.; Family Medicine; 4050 Dublin Blvd 2nd floor, Dublin, CA 94568; 925-975-6100
I acknowledge that my mental health record and alcohol/drug treatment information, if applicable, will be released to UC EAP, yes

Further, I authorize the University of California, Education Abroad Program (UCEAP) and its agents to contact my emergency contact as indicated on the emergency for, in connection with my general welfare abroad.

By clicking this checkbox, I am signing this form with my electronic signature, as I authorized with my CalNet ID to access eTang. It will be date and time stamped when I submit the completed form. yes
I understand that the UHS EAP Coordinator will follow up with me within 2 weeks through a secure message and I will be notified that my form has been received. yes
University of California Education Abroad Program
2017-2018

Policy Number: ADD No4834823

Activity Covered: University of California, Education Abroad Program 24/7 worldwide coverage starts 14 days before the official UCEAP program and ends 31 days after the official end of the program.

Insured Persons: Class 1: All registered students and counselors participating in the "Overseas Study Trips" sponsored by the University of California.

Dependents of Class 1 Insureds are eligible for Coverage under this Policy if the student pays premium directly to ACI.

Medical Benefits

<table>
<thead>
<tr>
<th>Medical Benefit</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Death &amp; Dismemberment Benefit</td>
<td>$20,000</td>
</tr>
<tr>
<td>Accident or Sickness Expense Benefits</td>
<td>$500,000</td>
</tr>
<tr>
<td>Dental Treatment (injury only)</td>
<td>$500 per tooth, subject to a $5,000 maximum</td>
</tr>
<tr>
<td>Maximum for Emergency Sickness Dental Care and Treatment</td>
<td>$2,000 (services include but are not limited to extractions, temporary or restored fillings and root canal)</td>
</tr>
<tr>
<td>Maximum for Mental &amp; Nervous</td>
<td>Treated as any other medical condition</td>
</tr>
<tr>
<td>Maximum for Substance Abuse</td>
<td>Treated as any other medical condition</td>
</tr>
<tr>
<td>Maximum for Prescription Drugs</td>
<td>100% of the usual and customary charges</td>
</tr>
<tr>
<td>Maximum for Birth Control/Elective Termination of Pregnancy</td>
<td>$500</td>
</tr>
<tr>
<td>Anti-malarial medication prescribed by a doctor</td>
<td>100% if purchased within term of coverage</td>
</tr>
</tbody>
</table>

*Prescription anti-malarial medication is covered under this plan, provided it is 1) prescribed by a doctor and 2) the prescription is filled and paid for while coverage is in effect under the policy (14 days before the official start of the UCEAP program and 31 days after the official end of the UCEAP program)*

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical evacuation, repatriation of remains and security evacuation expense</td>
<td>100% of covered expenses</td>
</tr>
<tr>
<td>Emergency Reunion Benefit</td>
<td>Up to $500 per day for up to ten (10) days</td>
</tr>
</tbody>
</table>
**Non-Medical Benefits**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Hotel Convalescence, if medically necessary</td>
<td>Benefit Maximum: $100 per day subject to a maximum of $700</td>
</tr>
<tr>
<td>Lost Baggage Benefit</td>
<td>Benefit Maximum: Up to $1,000 per bag not to exceed $2,000 per trip (subject to $25 deductible)</td>
</tr>
<tr>
<td>Personal Property Benefit</td>
<td>Benefit Maximum: Up to $2,500 per item or set of items not to exceed the actual purchase price, to a maximum of $5,000 (subject to $25 deductible)</td>
</tr>
<tr>
<td>Financial Instrument Reimbursement Benefit</td>
<td>Benefit Maximum $500 per trip, maximum $500 for cash</td>
</tr>
<tr>
<td>Trip Cancellation and Interruption Benefit</td>
<td>Benefit Maximum: $2,000</td>
</tr>
<tr>
<td>Trip Delay Benefit</td>
<td>Benefit Maximum: $200 per day for up to 5 days</td>
</tr>
</tbody>
</table>

**Emergency Assistance Services (medical referrals, prescriptions, evacuation, repatriation):**

Call UnitedHealthcare Global if in the United States, Canada, Puerto Rico, US Virgin Islands, Bermuda: 1-800-527-0218; outside of these areas, call collect: 1-410-453-6300; E-mail assistance@uhcglobal.com. Identify yourself as a UCEAP student and provide your UHCG Group ID (362881).

**Claims Instructions:**

For coverage inquiries, claim forms or claim status, please call:
Administrative Concepts, Inc. (ACI)
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087

**Phone Numbers:**  
1-888-293-9229 (from inside the USA)  
1-610-293-9229 (from outside the USA)

**Fax:**  
1-610-293-9299

**Email:**  
claims@acitpa.com

**Disclaimer:** This is a summary of the program and does not represent the entire contract terms, conditions and exclusions. It is not an insurance contract. Insurance benefits are underwritten by ACE American Insurance Company. If there is any discrepancy between this summary and the master policy, the master policy will govern.
What is not covered?

We will not pay benefits for any loss or injury that is caused by or results from:

- intentionally self-inflicted injury; suicide or attempted suicide (applicable to Accidental Death and Dismemberment only).
- war or any act of war, whether declared or not.
- piloting or serving as a crewmember in any aircraft (except as provided by the Policy).
- commission of, or attempt to commit, a felony.
- commission of or active participation in a riot or insurrection.

In addition, we will not pay Medical Expense Benefits for any loss, treatment, or services resulting from, or contributed to by:

- Services, supplies, or treatment, including any period of hospital confinement that was not recommended, approved and certified as medically necessary and reasonable by a doctor, or expenses that are not medical in nature.
- Injury sustained while participating in professional sports.
- Routine physicals.
- Cosmetic surgery, except for reconstructive surgery needed as the result of an injury or sickness.
- Elective surgery (except as provided by the Policy). Any elective treatment, surgery, health treatment or examination (a) deemed by Us to be experimental; and (b) are not recognized and generally accepted medical practices in the United States.
- Dental care, except as the result of injury to natural teeth caused by accident or for emergency pain relief treatment to sound, natural teeth.
- Emergency sickness dental expenses incurred for; Routine oral examinations; Fluoride applications; Prosthetics (new and repaired); Expenses for more than one dentist in excess of those that would have been incurred had all services been performed by one dentist; Expenses in excess of the lowest fee in cases where there are optional treatment techniques carrying different fees; Services primarily for cosmetic or aesthetic purposes; Orthodontics; Treatment already in progress or recommended by a dentist within six months of the Covered Person’s effective date of coverage; Replacement of denture or orthodontic appliance due to loss or theft; Denture or bridgework replacement of teeth extracted prior to the Covered Person’s effective date of coverage; Expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain.
- Eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof, unless caused by an Injury incurred while covered under the Policy.
- Treatment by an immediate family member or member of Covered Person’s household.
- Treatment furnished under any mandatory government program or facility set up for treatment without cost to any individual.
- Expenses payable by any automobile insurance without regard to fault.
- Nasal or sinus surgery, except surgery made necessary as a result of a covered injury.
- Injury or sickness where the Covered Person’s trip to the host country is undertaken for treatment or advice for such injury or sickness.
- Birth control including surgical procedures and devices (except as provided by the Policy)
- Elective termination of pregnancy (except as provided by the Policy).
In addition to the General Exclusions, We will not pay Lost Baggage and Personal Property Benefits for:

- loss or damage due to:
  - moth, vermin, insects, or other animals; wear and tear; atmospheric or climatic conditions; or gradual deterioration or defective materials or craftsmanship; mechanical or electrical failure; any process of cleaning, restoring, repairing, or alteration.
  - more than a reasonable proportion of the total value of the set where the loss or damaged article is part of a set or pair.
  - devaluation of currency or shortages due to errors or omissions during monetary transactions.
  - any loss not reported to either the police or transport carrier within 24 hours

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims.

**IMPORTANT NOTICE**

The policy provides travel insurance benefits for students traveling outside of their home country. The policy does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and does not satisfy a person’s individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA). For more information about the ACA, please refer to www.HealthCare.gov and Covered California https://www.coveredca.com.

**Disclaimer:** This is a summary of the program and does not represent the entire contract terms, conditions and exclusions. It is not an insurance contract. Insurance benefits are underwritten by ACE American Insurance Company. If there is any discrepancy between this summary and the master policy, the master policy will govern.
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CONFIDENTIAL

MEDICAL QUESTIONNAIRE TO BE COMPLETED PRIOR TO ACCEPTANCE FOR ADMISSION TO THE UNIVERSITY OF THE WEST INDIES (CAVE HILL CAMPUS)

Part A is to be completed and signed by the applicant

Part B is to be completed by a Registered Medical Practitioner who has examined the applicant.

Both parts must be completed by writing “Yes” or “No” in the proper space. If “Yes” is answered, the details relevant to the question must be inserted.

Positive answers do not necessarily imply the refusal of the applicant. Answers given to the questions will be of assistance to the student in his/her University career.

PART A

Applicant’s Last Name: ________________________________________________________

First Name(s): _______________________________________________________________

Address: ____________________________________________________________________

Age: __________________

Name of Parent/Guardian/Next of Kin: ____________________________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever had:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is there any physical or mental disorder for which you may need special attention or supervision during your studies?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SIGNED: ____________________________

DATE: ____________________________
PART B

TO BE COMPLETED BY THE PHYSICIAN AFTER PART A
HAS BEEN COMPLETED BY APPLICANT

Please note below any conditions you consider significant. If there is any other information of which we should be aware please submit separately under confidential cover.

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is there any abnormality on general physical examination including urine test?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>*Is there any physical or mental disability which might handicap the candidate in his/her studies?</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Is there any evidence of recent infectious disease?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Is there any history of allergies or adverse drug reactions?</td>
<td></td>
</tr>
</tbody>
</table>
| 5. | Has the candidate been treated for any of the following:  
- Asthma  
- Epilepsy  
- Hypertension  
- Diabetes | |
| 6. | **Is the candidate immunized against:  
- Tetanus  
- Diphtheria  
- Anterior Poliomyelitis  
- B.C.G.  
- Rubella  
- Hepatitis B | |

*If YES, please forward, thorough patient medical details under confidential cover, to Doctor, Student Health Service, The University of the West Indies, Cave Hill Campus

**Patient is required to submit documented details

SIGNED: ________________________________

FULL NAME: ________________________________

ADDRESS: ____________________________________________
_________________________________________________________________
_________________________________________________________________

DATE: ________________________________________
MALARIA PROPHYLAXIS
PARTICIPATION AGREEMENT

I (Print Student Name) understand that malaria is present in various parts of Botswana year-round, including in urban areas, though not in Gaborone. I understand that travelers to sub-Saharan Africa have the greatest risk of both getting malaria and dying from their infection. I understand that transmission is generally higher in Africa south of the Sahara than in most other areas of the world.

I understand that most residents of the United States have never developed resistance (immunity) to the disease and that malaria infection in a non-immune person can quickly result in a severe and life-threatening illness.

I agree to consult with my UC campus Student Health Services physician before my participation in the Education Abroad Program in Botswana regarding the anti-malaria prophylaxis treatment most appropriate and learn about personal protective measures.

I agree to continue the prescribed malaria prophylaxis regime if I plan to leave the urban Gaborone area and that missed or delayed doses may increase the risk of getting malaria.

I understand that anti-malarials are not 100% effective so insect protection measures are essential in addition to any prophylactic regimen. I agree that I will follow personal protection measures (i.e. wear appropriate clothing, use permethrin-treated bed nets, use of aerosol insecticides, vaporizing mats and mosquito coils, etc.)

As a voluntary participant in the Education Abroad Program in Botswana, I will follow the doctor’s recommended malaria prophylaxis as prescribed and I certify that I have read and understood the above. I understand that failure to comply with these requirements could result in my dismissal from the program.

Signature of Student ________________________________

UC Campus __________________ Date ____________________

Updated January 2012
This page intentionally left blank.
Sample Chinese health form for students that will be studying in China for more than six months (ex. BNU Summer+Fall, Peking University Year) and will apply for a residence permit after arrival.

**PHYSICAL EXAMINATION RECORD FOR FOREIGNER**

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Citizenship</th>
<th>Blood Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last, First</td>
<td></td>
<td>YYYY-MM-DD</td>
<td>Must match passport.</td>
<td></td>
</tr>
</tbody>
</table>

Present mailing address

<table>
<thead>
<tr>
<th>Current address</th>
<th>Place of birth</th>
<th>State and country</th>
</tr>
</thead>
</table>

Photo officially stamped by clinic, hospital, or physician.

Have you ever had any of the following diseases? (Each item must be answered “Yes” or “No”)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typhus fever</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Relapsing fever</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Typhoid and paratyphoid fever</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Have you ever had any of the following diseases or disorders endangering the Public order and security? (Each item must be answered “Yes” or “No”)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toxicomania</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mental confusion</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Manic psychosis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Paranoid psychosis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hallucinatory psychosis</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

The remainder of the form must be completed in full by the physician. Please note metric measurement units.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm</td>
<td>kg</td>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Eyes</td>
<td>Lymph nodes</td>
<td></td>
</tr>
<tr>
<td>Colour sense</td>
<td>Skin</td>
<td>Lungs</td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td>Nose</td>
<td>Tonsils</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6 month residency - China (continued)

<table>
<thead>
<tr>
<th>Spine</th>
<th>Extremities</th>
<th>Nervous system</th>
</tr>
</thead>
<tbody>
<tr>
<td>其它所见</td>
<td>附件</td>
<td>官方印章</td>
</tr>
<tr>
<td>Other abnormal findings</td>
<td>Attach original X-ray report, not films. Photocopies are not accepted.</td>
<td>Attach original printout.</td>
</tr>
</tbody>
</table>

**Chest X-ray exam.**

- Attach original X-ray report, not films.
- Photocopies are not accepted.

**ECG**

- Must state clearly:
  - AIDS – negative or positive
  - Syphilis – negative or positive
  - The original HIV test must be attached, photocopies are not accepted.

**Laboratory exam.**

- HIV, Syphilis serodiagnosis
- If none found, physician should write "none found."

**Suggestion**

- If any.

**Physician that completed the exam signs and dates the form.**

**Signature of physician**

**Date**

YYYY-MM-DD
MALARIA PROPHYLAXIS
PARTICIPATION AGREEMENT

I (Print Student Name) ________________________________
understand that malaria is present throughout Ghana year-round, including in urban areas. I understand that travelers to sub-Saharan Africa have the greatest risk of both getting malaria and dying from their infection. I understand that transmission is generally higher in Africa south of the Sahara than in most other areas of the world.

I understand that most residents of the United States have never developed resistance (immunity) to the disease and that malaria infection in a non-immune person can quickly result in a severe and life-threatening illness.

I agree to consult with my UC campus Student Health Services physician before my participation in the Education Abroad Program in Ghana regarding the anti-malaria prophylaxis treatment most appropriate and learn about personal protective measures.

I agree to continue the prescribed malaria prophylaxis regime through my stay in Ghana and that missed or delayed doses may increase the risk of getting malaria.

I understand that such malaria prophylaxis is required by the regulations of the University of Ghana.

I understand that anti-malarials are not 100% effective so insect protection measures are essential in addition to any prophylactic regimen. I agree that I will follow personal protection measures (i.e. wear appropriate clothing, use permethrin-treated bed nets, use of aerosol insecticides, vaporizing mats and mosquito coils, etc.)

As a voluntary participant in the Education Abroad Program at the University of Ghana, I will follow the doctor’s recommended malaria prophylaxis as prescribed and I certify that I have read and understood the above. I understand that failure to comply with these requirements could result in my dismissal from the program.

Signature of Student ______________________________________________________

UC Campus __________________________ Date __________________________

Updated January 2012
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HEALTH HISTORY FORM

Name: ____________________________ (Surname, Other names)  (Chinese)

Sex: M/ F Date of Birth: ____________ Place of Birth: ____________ Marital Status: Single/ Married

Home Address: ____________________________ Phone: Home: ____________

Correspondence Address (if different): ____________________________ Mobile: ____________________________

Nationality: ____________________________

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name: ____________________________ Relationship: ____________________________ Phone: ____________________________

Address: ____________________________

FAMILY HISTORY:

<table>
<thead>
<tr>
<th>Relation</th>
<th>Sex/Age</th>
<th>Occupation</th>
<th>State of Health</th>
<th>Cancer</th>
<th>Heart Disease</th>
<th>Hypertension</th>
<th>Diabetes</th>
<th>Hypercholesterolemia</th>
<th>Mental Illness</th>
<th>If Deceased</th>
<th>Cause &amp; Age of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Brothers</td>
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<tr>
<td>&amp; Sisters</td>
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<td></td>
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</tr>
</tbody>
</table>

HEALTH PROBLEMS:

Have you ever had the followings? Yes ☐ No ☐

Allergic Rhinitis ☐ ☐

Asthma ☐ ☐

Eczema/Dermatitis ☐ ☐

Thyroid Disease ☐ ☐

Ulcer Pain ☐ ☐

Anaemia ☐ ☐

Operation ☐ ☐

Hospitalization ☐ ☐

If yes, please specify (Date; Duration; Treatment & Follow-up):

LONG TERM MEDICATIONS 長期服用藥物

Name: ____________________________ Dosage & Frequency: ____________________________ Date started (if known): ____________________________

1. 2. 3.

Are you ALLERGIC to any food/medications? Yes ☐ ☐ No ☐ ☐ If Yes, please specify: ____________

MENSTRUAL HISTORY (For female students only) 月經週期（只適用於女生）

Age of first menstruation: ____________ Duration between periods: _______ Days Number of days of menses: _______ Days

Quantity of menses: ☐ scanty ☐ moderate ☐ excessive ☐

Menstrual Pain: ☐ nil ☐ mild ☐ moderate ☐ severe ☐
Hong Kong (continued)

**Do you smoke?**
- Yes □
- No □
- If yes, please specify how many? _______ pack/day _______years

**Do you drink alcohol?**
- Yes □
- No □
- If yes, please specify how much? _______ drinks/week

In the past 3 months, did you have:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Cough for more than 4 weeks?</td>
<td>□</td>
</tr>
<tr>
<td>(ii) Cough with blood stained sputum?</td>
<td>□</td>
</tr>
<tr>
<td>(iii) Unexplained low grade fever?</td>
<td>□</td>
</tr>
<tr>
<td>(iv) History of contact with T.B. patients?</td>
<td>□</td>
</tr>
</tbody>
</table>

Do you frequently have insomnia, feel anxious or emotional upset?
- Yes □
- No □

Do you need counseling or like to discuss confidentially with the health staff for your personal, health, social or emotional problem?
- Yes □
- No □

Do you have any physical handicap which may require special provisions to adjust to university life?
- Yes □
- No □

Are you troubled by any defect in speech?
- Yes □
- No □

Do you have any impairment of hearing?
- Yes □
- No □

**IMMUNIZATION** (Please √ and including dates if possible)

<table>
<thead>
<tr>
<th>First Dose</th>
<th>Second Dose</th>
<th>Third dose</th>
<th>First Dose</th>
<th>Second Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>Measles, Mumps, Rubella</td>
<td>Bacillus Calmette-Guérin (BCG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twinrix</td>
<td>Chickenpox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT</td>
<td>HPV Vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus Toxoid</td>
<td>Other Vaccines</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: ____________________  Student Signature: ____________________

For Official Use

- Body Weight (kg) __________
- Height (m) __________
- BMI __________
- Blood Pressure __________/
- Remarks ____________________

RETURN COMPLETED FORM TO:

- The Director
- University Health Service
- The Chinese University of Hong Kong
- Shatin, N.T.

August 2008
NOTES TO THE EXAMINING PHYSICIAN: Your medical report is necessary for our evaluation of the student's application request. Any applicant who has been under the care of a specialist must submit a written detailed report giving complete diagnosis, prognosis, and evaluation. If any changes arise in the applicant's condition within the last 10 days before departure, the applicant must submit a full explanatory medical letter. This information will be treated confidentially. Please return the completed form to: Overseas Student Program, Ben-Gurion University of the Negev, 1001 Avenue of the Americas, 19th Floor, New York, NY 10018.

APPLICANT'S INFORMATION
Name _________________________________ Date of Birth ___________ ☐ M ☐ F ☐ Another gender ________________
Permanent Address
_________________________________________________________________________________________________
City                                           State/Province          Postal Code          Country
Contact Information (_____)_____________   _____________________________________________________
Cell Phone                         Email
IMPORTANT: If parents are not available in case of emergency, please notify:
Name ___________________________________________     Relationship to Participant __________________________________
Home Phone _______________ Work Phone _______________ Email Address __________________________________________

HEALTH HISTORY (Please answer “Yes” or “No” to the following)

Y N Y N Y N Y N
Allergies          ☐ ☐ Diabetes       ☐ ☐ Frequent Colds    ☐ ☐ Pneumonia    ☐ ☐ 
Hay Fever          ☐ ☐ Dizziness     ☐ ☐ German Measles   ☐ ☐ Poliomyelitis ☐ ☐ 
Sting              ☐ ☐ Drug Use       ☐ ☐ Headaches       ☐ ☐ Rheumatic Fever ☐ ☐ 
Penicillin         ☐ ☐ Ear Infections ☐ ☐ Heart Trouble  ☐ ☐ Scarlet Fever  ☐ ☐ 
Asthma             ☐ ☐ Eating Disorders ☐ ☐ Kidney Trouble ☐ ☐ Sleep Walking  ☐ ☐ 
Bronchitis         ☐ ☐ Epilepsy       ☐ ☐ Measles         ☐ ☐ Thyroid Disorders ☐ ☐ 
Chicken Pox        ☐ ☐ Eye Trouble    ☐ ☐ Mononucleosis   ☐ ☐ Tuberculosis   ☐ ☐ 
Convulsions        ☐ ☐ Fainting       ☐ ☐ Mumps           ☐ ☐ Venereal Disease ☐ ☐ 
Other              ☐ ☐ Other          ☐ ☐ Other           ☐ ☐ Other          ☐ ☐ 

Please give all details concerning any question to which “Yes” is answered above, including details of medications required.

Has the applicant ever suffered any chronic or recurring illness? If yes, give details.

Has the applicant undergone any operation or sustained serious injuries? If yes, give details.

Is the applicant taking any medication now? If so, please specify the name of medication(s) and condition being treated. Please note that students taking prescription medication should bring a supply to last the entire time abroad.

If yes to any of the above questions, has a treatment plan been established for the applicant while abroad? ☐ Yes ☐ No
### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Deviation from Normal</th>
<th>Normal</th>
<th>Deviation from Normal</th>
<th>Normal</th>
<th>Deviation from Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>o</td>
<td>o</td>
<td>Lungs</td>
<td>o</td>
<td>Blood Pressure</td>
<td>o</td>
</tr>
<tr>
<td>Eyes</td>
<td>o</td>
<td>o</td>
<td>Abdomen</td>
<td>o</td>
<td>Hemoglobin</td>
<td>o</td>
</tr>
<tr>
<td>Ears</td>
<td>o</td>
<td>o</td>
<td>Tonsils</td>
<td>o</td>
<td>Urinalysis</td>
<td>o</td>
</tr>
<tr>
<td>Hearing</td>
<td>o</td>
<td>o</td>
<td>Feet</td>
<td>o</td>
<td>Albumin &amp; Sugar</td>
<td>o</td>
</tr>
<tr>
<td>Nose</td>
<td>o</td>
<td>o</td>
<td>Spine</td>
<td>o</td>
<td>Microscopic</td>
<td>o</td>
</tr>
<tr>
<td>Teeth</td>
<td>o</td>
<td>o</td>
<td>Appendix</td>
<td>o</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>o</td>
<td>o</td>
<td>Hernia</td>
<td>o</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Weight ___________ Height ___________ Blood Type ___________ Blood Pressure ___________ Pulse ___________

### PSYCHOLOGICAL

Is the individual currently involved in psychological therapy of any kind? ☐ Yes ☐ No

If yes, with whom? ☐ Psychiatrist ☐ Psychologist ☐ Counselor ☐ Social Worker

Is the individual receiving any medication? ☐ Yes ☐ No If yes, please specify: ______________________________

Is there any history of psychological or psychiatric care? ☐ Yes ☐ No If yes, give dates: ______________________________

Has the applicant ever been advised to have counseling, psychotherapy, or psychiatric care? ☐ Yes ☐ No

Additional comments:

________________________________________________________________________

Please note that the BGU campus is not fully accessible to all disabled students. Please contact the New York office if you have any questions regarding accessibility and accommodations.

### PHYSICIAN’S STATEMENT

(We will not accept forms signed by family members. Please attach a business card or office stamp)

I have read the Notes to the Examining Physician on the first page of the Medical Form and thereafter examined ____________________. The results I have recorded represent, to the best of my knowledge, the entire applicant's medical history and my findings on examination. I understand that the program organizers in Israel will rely on my report. In my opinion the applicant is physically, mentally, and emotionally capable of participating in the Overseas Student Program at Ben-Gurion University of the Negev.

☐ Yes ☐ No If no, please specify: ______________________________

I recommend full physical activity ☐ Yes ☐ No If no, please specify: ______________________________

I recommend certain restrictions ☐ Yes ☐ No If yes, please specify: ______________________________

The applicant can withstand certain changes in diet from which he/she is accustomed.

☐ Yes ☐ No If no, please specify: ______________________________

Physician’s Name ___________________________ Physician’s signature ___________________________

Address _____________________________________ Phone __________________ License Number ___________________________________

### APPLICANT’S STATEMENT

I have read the "Notes to the Examining Physician" on the first page of the Medical Form. I hereby certify that, to the best of my knowledge, this medical form is complete in all its details and fully realize that any condition, mental or physical, that I am found to have, originating prior to my arrival in Israel, and which is not described in full in this form or in any accompanying letter, will be due cause for my return to my country of origin, or treatment in Israel solely at my expense, and that the Program has neither responsibility nor liability arising out of such condition. I also realize that medical coverage does not include dental treatment or any form whatsoever, or eyeglasses.

Name of Applicant ___________________________ Applicant’s signature ___________________________

Date ________________ Signature of Parent/Guardian (if applicant under 18) ___________________________
Report of Medical Examination

Please keep in mind that we do not accept forms completed by a relative. Incomplete forms will not be accepted.

The applicant should complete this section.
Please type or print clearly and bring a copy of this form with you to Jerusalem.

Name of Applicant ____________________ Social Security Number __________
Please indicate the program to which you are applying ______
Address _______________________________________________________________
E-mail Address ________________________________________________________

The physician should complete the remainder of this report of medical examination.

To the examining physician - Your health evaluation is an essential part of the application for participation in study abroad programs at the Hebrew University. We require a full physical examination. Please include results of your lab work on this report; do not submit lab reports with this evaluation.

Date of Birth ____________________ Age ____________________ Gender __________

Past or present illnesses (Please give dates, complications, and any residual symptoms):

A. History of heart disease (valve disorders, congenital malfunctions, etc.) ______________________
B. Rheumatic fever (heart involvement) ______________________
C. Diseases of the digestive tract: (peptic ulcer; biliary tract disease, chronic or recurrent diarrhea, severe constipation, vomiting spells, hernia, appendicitis) ______________________
D. Respiratory diseases (tuberculosis, asthma, chronic bronchitis, bronchiectasis, sinus disease) ______
E. Urinary tract diseases (nephritis, nephrosis, calculi, recurrent bladder or prostatic disease, history of urinary tract infection) ______________________
F. Disorders of menstruation (give details) ______________________
G. Diabetes mellitus ______________________
H. Hypertension ______________________
I. Migraine or severe headaches (dizzy spells, strokes) ______________________
J. Epilepsy, fainting spells, history of head injuries ______________________
K. Muscle disease ______________________
L. Allergic diseases (hay fever, food allergies). Please record causative factors ______________________
M. Chronic skin diseases ______________________
N. Severe injuries ______________________
O. Surgeries (list surgeries and dates. If none, write "none") ______________________
P. Systemic disease (juvenile rheumatoid arthritis, lupus, erythematosis) ______________________
Name of Applicant ____________________ Social Security Number _______________

Please conduct a complete examination: Height ___________ Weight ________________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Deviation from Normal</th>
<th>Normal</th>
<th>Deviation from Normal</th>
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</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td>Lungs</td>
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<tr>
<td>Eyes</td>
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<td>Abdomen</td>
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<td>Hearing</td>
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<tr>
<td>Nose</td>
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<td>Spine</td>
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<tr>
<td>Teeth</td>
<td></td>
<td>Blood pressure</td>
<td></td>
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<tr>
<td>Heart</td>
<td></td>
<td>Urinalysis (dipstick &amp; microscopic, if indicated)</td>
<td></td>
</tr>
</tbody>
</table>

1. List special dietary requirements (i.e., low sodium) ________________________________

2. If the applicant is receiving any medication, please attach statement of such medication with dosage and instructions to keep on file.

3. Bearing in mind the various conditions imposed by a foreign study program (lengthy absence from home, adjustment to a foreign culture, different living conditions, etc.), is the applicant emotionally stable for study abroad?
   ☐ Yes ☐ No, please describe: ____________________________________________________

4. To your knowledge, has the applicant been treated by a psychologist or psychiatrist? In such cases, a supporting letter from the treating psychologist or psychiatrist may be requested.
   ☐ No ☐ Yes, please describe: ____________________________________________________

5. Restrictions on physical activity, including exercise in a fitness facility:
   ☐ None ☐ As follows: ____________________________________________________________

I have examined the above-named applicant and consider him/her physically qualified to participate in study at the Hebrew University.

Name of Physician (please type or print) ______

_________________________________________ Signature of Physician

_________________________________________ Telephone

License No. ______________________________ Date __________________

Please return the completed form to:
Office of Academic Affairs • One Battery Plaza, 25th Floor • New York NY, 10004
Tel: 1 800-404-8622 or 1 212-607-8520 • Fax: 1 212-809-4183 • E-mail: hebrewu@hebrewu.com
Student Health Declaration

All fields marked with an asterisk (*) are required

I the undersigned:

*Full Name: _____________________  *Citizenship: ___________________
*Social Security Number or SIN Number: ____________________________
*Permanent Address: ____________________________________________

*1.  □ My health condition is normal and I do not have any illness
    □ I have the following illness (please specify)*

____________________________________________________________________________________________
____________________________________________________________________________

*2.  □ I am currently not receiving medical care
    □ I am currently receiving medical care (please specify)*

____________________________________________________________________________________________
____________________________________________________________________________

*3.  □ I have never received any mental health treatment
    □ I have received mental health treatment (please specify)*

____________________________________________________________________________________________
____________________________________________________________________________

*4.  □ I have never had drug or alcohol-related problems
    □ I have had drug or alcohol-related problems (current/past)*

____________________________________________________________________________________________
____________________________________________________________________________

*5.  □ I have never been hospitalized for medical reasons
    □ I have been hospitalized for medical reasons *
    In (hospital):

    For the following reason(s):

____________________________________________________________________________________________
____________________________________________________________________________

*6.  □ I do not have learning disabilities
    □ I have learning disabilities that require me to receive special study conditions and considerations during
    the course of study and/or during exams.
    I have the following learning disabilities*:

____________________________________________________________________________________________
____________________________________________________________________________

I hereby declare and confirm the above information is accurate.

*Day _______  *Month _______  *Year_______ Signature _________________________

* Please provide copies of all diagnostic tests, medical reports and discharge summaries from hospitalization in this regard.

**I am aware that if found eligible to be accepted into the program, I will be required to sign a “Permission to Access Personal Medical
Records” form.

Please submit the complete application and additional documentation by May 30, 2015
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交換留学生用(For Exchange Students)

健康診断書 Health Certificate
(診断医に記入してもらってください/to be completed by the examining physician)

日本語又は英語により明確に記載すること。Please fill out (PRINT/TYPe) in Japanese or English.

氏名 Name: ____________________________
□男 Male 生年月日 Year / Month / Day
□女 Female Date of Birth: ____________

1. 身体検査 Physical Examination

(1) 身長 Height cm
体重 Weight kg

(2) 血圧 Blood pressure mm/Hg~ mm/Hg
血液型 Blood type
ABO RH
脈拍 Puls
regular

(3) 視力 Eyesight: (R) (L)
視覚 Without glasses
聴覚 With glasses or contact lenses

(4) 聴力 Hearing: □正常 normal 言語 Speech: □正常 normal

2. 申請者の胸部について、聴診とX線検査の結果を記入してください。X線検査の日付も記入すること（6ヶ月以上前の検査は無効）
Please describe the results of physical and X-ray examinations of the applicant's chest x-rays (X-rays taken more than 6 months prior to this certification are NOT valid).

肺 Lungs: □正常 normal 心臓 Cardiomegaly: □異常 impaired

心電図 Electrocardiograph: □正常 normal

異常がある場合 in case "impaired"

異常あり Foci

3. 現在治療中の病気 Under medical treatment at present
□Yes (Conditions/particulars: ____________________________)
□No

4. 既往歴 Past history: Please indicate with + or - and fill in the date of recovery

結核 Tuberculosis...□( )
マラリア Malaria...□( )
他の伝染病 Other communicable disease...□( )

epilepsy...□( )
腎臓病 Kidney disease...□( )
心臓病 Heart disease...□( )

diabetes...□( )
薬物過敏 Drug allergy...□( )
精神異常 Psychosis...□( )

5. 志願者の既往歴、診査・検査の結果から判断して、現在の健康の状況は充分に留学に耐えうるものと思われますか？Yes又はNoにチェックをしてください。
In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan?

Yes □ No □

6. 特記すべき事項
Particulars or additional comments:

日付 Date: ____________________________
署名 Signature: ____________________________

医師 氏名 Physician's Name (Print): ____________________________

検査施設名 Office / Institution: ____________________________

所在地 Address: ____________________________
# Certificate of Health

All sections must be filled in. Where □ is provided, please tick off appropriate box.

## Personal Information

<table>
<thead>
<tr>
<th>Name in English</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>(Surname)</td>
<td>(Given Name)</td>
<td>(Middle Name)</td>
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<table>
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<th>Sex</th>
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<tr>
<td>/ /</td>
<td></td>
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<tr>
<td>(Year) (Month) (Day)</td>
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<td>□ Female</td>
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## Examination Report

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<th>Height</th>
<th>cm</th>
<th>Weight</th>
<th>kg</th>
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<th>Without Glasses:</th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Glasses or Contact Lenses:</td>
<td>Left</td>
<td>Right</td>
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<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>/</th>
<th>mmHg</th>
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<table>
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<tr>
<th>Urine Test</th>
<th>protein ( )</th>
<th>sugar ( )</th>
<th>blood ( )</th>
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<table>
<thead>
<tr>
<th>Chest X-ray Examination</th>
<th>□ Normal</th>
<th>□ Impaired</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) *Required</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th></th>
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</thead>
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<td>/ /</td>
<td></td>
</tr>
<tr>
<td>(Year) (Month) (Day)</td>
<td>*Required</td>
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<table>
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<th>Disease currently being treated</th>
<th>□ No</th>
<th>□ Yes</th>
</tr>
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<tbody>
<tr>
<td>(Disease: )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If marked Yes, please describe in detail (medication and treatment):

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>□ No</th>
<th>□ Yes</th>
</tr>
</thead>
</table>

If marked Yes, please describe in detail:

<table>
<thead>
<tr>
<th>Disabilities</th>
<th>□ Negative</th>
<th>□ Positive</th>
</tr>
</thead>
</table>

If marked positive, please describe in detail:

## Diagnosis

*In my opinion, this applicant is able to participate fully in the school program.*

<table>
<thead>
<tr>
<th>Date of Examination</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Year) (Month) (Day)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Institution:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name and Title of Physician (please print):</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature/Seal of Physician:</th>
<th></th>
</tr>
</thead>
</table>
### HEALTH REPORT

**Internationale Christian University**

**ICU Form VIII**

| Japan - ICU Application No. ______________ |

Note: This form will be used solely for the purpose of managing your health while at ICU. Information received will be strictly protected and will not be used for any other purpose.

Please have a check-up with your physician 6 months prior to the date of matriculation and have this form completed (omitting no section). Please understand that there may be instances in which treatment, examinations and medicine available in Japan may differ from the care received in your home country. You should bring any medicine you will need during your stay in Japan.

<table>
<thead>
<tr>
<th>本人記入欄 / TO BE FILLED IN BY YOURSELF PLEASE WRITE LEGIBLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>姓(Family)</td>
</tr>
<tr>
<td>名(Given)</td>
</tr>
<tr>
<td>Date of Birth 19____年____月____日</td>
</tr>
<tr>
<td>year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>医師記入欄 / TO BE COMPLETED BY YOUR PHYSICIAN (NOT PARENT) 様書でご記入ください / PLEASE WRITE LEGIBLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 身長</td>
</tr>
<tr>
<td>Height</td>
</tr>
<tr>
<td>3. 視力</td>
</tr>
<tr>
<td>视力</td>
</tr>
<tr>
<td>Vision</td>
</tr>
<tr>
<td>4. 聴覚</td>
</tr>
<tr>
<td>聴覚</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>5. 検尿</td>
</tr>
<tr>
<td>尿分析</td>
</tr>
<tr>
<td>Urinalysis</td>
</tr>
<tr>
<td>6. 血圧</td>
</tr>
<tr>
<td>7. 胸部エックス線検査またはツベルクリン反応： 以下のAまたはBのいずれかを記載して下さい。</td>
</tr>
<tr>
<td>Chest x-ray OR tuberculin skin test / QuantIFERON-TB Gold. Please fill out one of the following (A or B).</td>
</tr>
<tr>
<td>A. 胸部エックス線検査 Chest x-ray</td>
</tr>
<tr>
<td>• 6ヶ月以内のものに限る</td>
</tr>
<tr>
<td>• Must have been taken within 6 months</td>
</tr>
<tr>
<td>撮影年月日</td>
</tr>
<tr>
<td>所見: 正常 / 异常</td>
</tr>
<tr>
<td>Findings: Normal / Abnormal</td>
</tr>
<tr>
<td>Please describe</td>
</tr>
</tbody>
</table>

| B. ツベルクリン反応 Tuberculin skin test |
| クオントィフェロンTBゴールド QuantIFERON-TB Gold |
| • 6ヶ月以内のものに限る |
| • Must have been taken within 6 months |
| 検査日 | Date of test |
| 結果 | 陰性 | 陽性* |
| Result | Negative | Positive* |

* 陽性の方は胸部エックス線検査も併せて受けて下さい。
* Individuals who tested positive should also have a chest x-ray.

※裏面もご記入下さい。《OVER》
8.主な既往症と罹患時の年齢（気管支喘息、心臓病、てんかん等）
Medical history and dates of illnesses (bronchial asthma, cardiac disease, epilepsy, etc.)

9.現在治療中の疾患や障がい
Disease or disorder currently under treatment

10.その他・特記事項(アレルギーの有無、持参薬)
Other (allergies, medication)

注意：日本にはない薬もあります。常用薬のある方は、日本滞在期間中の薬を必ずご持参下さい。

Note: This person is currently taking medicines not available in Japan. Those who are on medication should bring any necessary medicine for the duration of his/her stay in Japan. If it is expected that this person will need medical care while in Japan, he/she should bring a medical certificate in English issued by his/her physician.

11.予防接種歴 以下の病気になったこと、また予防接種を受けたことはありますか？
Immunizations: Has this person ever had the following diseases or received vaccinations?

<table>
<thead>
<tr>
<th>罹患 Disease</th>
<th>予防接種 Vaccination</th>
<th>1回目 1st</th>
<th>2回目 2nd</th>
<th>備考 Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td></td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>麻疹 Measles</td>
<td>Yes / No</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>風疹 Rubella / German Measles</td>
<td>Yes / No</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>流行性耳下腺炎 Mumps</td>
<td>Yes / No</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>水痘 Varicella / Chicken pox</td>
<td>Yes / No</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

診断の結果上記のとおり相違のないことを証明する。
I certify that this person’s physical condition is as stated above.

医療機関名及び住所(所在地)
Name and location of medical organization

年月日 Date: yy mm dd

医師氏名(楷書)
Name of Physician
(Please Print)

医師署名
Physician’s Signature
Please print NEATLY and CLEARLY

日本 - Keio

Keio University
For exchange students

健 康 診 断 書
Certificate of Health

注意事項 IMPORTANT NOTE

この健康診断書は、留学生活に影響を与える可能性のある健康上の問題について、事前に把握するためのものです。ご記入いただいた情報は機密情報として取り扱われ、交換留学の合否に影響はありません。

It is important that we be made aware of any medical or emotional problems which might affect you during your stay. The provided information will be treated as confidential and will not affect your admission into the program.

*This form must be completed by a medical physician. If you do not have antibodies against infectious diseases listed below, we strongly recommend that you get vaccinated.

<table>
<thead>
<tr>
<th>氏名</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>姓氏</td>
<td>Family</td>
</tr>
<tr>
<td>名</td>
<td>Given</td>
</tr>
<tr>
<td>ミドルネーム</td>
<td>Middle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>生年月日</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>性別</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>男</td>
<td>Male</td>
</tr>
<tr>
<td>女</td>
<td>Female</td>
</tr>
</tbody>
</table>

診断日 Date

医療機関名 Institution/Clinic

所在地 Address

医師氏名 Name of Physician

署名 Signature

診断事項・健康の状態 Examination Report・Current State of Health

眼の検査 Eye-sight

<table>
<thead>
<tr>
<th>左 (L)</th>
<th>右 (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>裸眼</td>
<td>Without glasses or contact lenses</td>
</tr>
<tr>
<td>矯正</td>
<td>With glasses or contact lenses</td>
</tr>
</tbody>
</table>

聴力 Hearing

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Impaired</th>
</tr>
</thead>
<tbody>
<tr>
<td>正常</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>異常</td>
<td>Impaired</td>
<td></td>
</tr>
</tbody>
</table>

胸部X線検査 Chest X-ray

撮影日 Date

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Day</th>
</tr>
</thead>
</table>

所見があれば記入してください。Describe the condition in detail.

*1年内に実施したPPDまたはIGRA検査（結核の血液検査）の結果、陰性だった場合には、胸部X線は省略可。

Chest X-ray can be omitted if the results were negative for PPD or IGRA (TB blood test) tests taken within one year.

Please indicate the date and results of the examination below.

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>(Month)</td>
</tr>
</tbody>
</table>

感染症などの病歴について Record of infectious diseases and immunization

以下の感染症にかかったこと、および予防接種を受けたことがありますか。

Has the student ever had the following diseases and/or received vaccination?

<table>
<thead>
<tr>
<th>病名</th>
<th>Measles</th>
<th>Rubella</th>
<th>Mumps</th>
<th>Varicella</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Vaccinated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date of Recovery/Vaccination:</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date of Recovery/Vaccination:</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>

学業上配慮すべき健康上の問題 Medical conditions which might affect the student's academic performance

主な既往症や持病はありますか？ Has the student had any serious medical problems or chronic illnesses in the past?

<table>
<thead>
<tr>
<th>有</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>有</td>
<td>Yes</td>
</tr>
<tr>
<td>無</td>
<td>No</td>
</tr>
</tbody>
</table>

心身の症状は障害に関する所見 Are there any physical or mental conditions that may limit the student's ability to study?

<table>
<thead>
<tr>
<th>有</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>有</td>
<td>Yes</td>
</tr>
<tr>
<td>無</td>
<td>No</td>
</tr>
</tbody>
</table>

食物・薬物アレルギーがあれば記入してください。 Does the student have any food or drug allergies?

<table>
<thead>
<tr>
<th>有</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>有</td>
<td>Yes</td>
</tr>
<tr>
<td>無</td>
<td>No</td>
</tr>
</tbody>
</table>

この学生は精神的及び身体的に、海外での留学に適した状態にあるとお考えになりますか。Do you consider the student to be in adequate mental and physical health to participate in the study abroad program?

<table>
<thead>
<tr>
<th>有 (Adequate)</th>
<th>No (Inadequate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>有</td>
<td>Yes</td>
</tr>
<tr>
<td>無</td>
<td>No</td>
</tr>
</tbody>
</table>

思い出の番号 63
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Appendix Declaration of intent to undergo a TB test

In order to obtain a residence permit, you (or the person you represent) must be prepared to undergo a tuberculosis (TB) test and - if necessary - treatment. If you submit the completed declaration of intent to undergo a TB test to the IND together with your application (and also meet all other conditions), the IND will grant you a residence permit as soon as possible.

You are granted this permit under the express condition that you will actually undergo a TB test within three months. Should it become clear after the issue of a residence permit that - despite signing the declaration of intent - you failed to undergo a TB test within the period of three months, this may result in a cancellation of the permit that was granted.

Enclose the completed and signed declaration of intent with your application before you make an appointment with the Municipal Health Service. In doing so, you declare that you are prepared to undergo a TB test and, if necessary, TB treatment. For the appointment with the Municipal Health Service, you must complete the referral form as much as possible (part 1) and take it with you.

The obligation to undergo the test does not apply if you are a national of one of the following countries: one of the Member States of the EU or the EEA, Australia, Canada, Israel, Japan, Monaco, New Zealand, Suriname, United States of America and Switzerland (including Liechtenstein). Nor does the obligation to undergo the test apply if you have an EU residence permit for long-term residents issued by another EU country or are his/her family member and were already admitted to another EU country as a family member of the long-term resident.

1 Details of foreign national to be tested (the applicant)

1.1 Application for a permit for the purpose of work, wealthy foreign national, learning while working or study?
   - Yes
   - No

1.2 V-number (leave blank)

1.3 Name
   - Surname as stated in the border-crossing document
   - First names

1.4 Sex and Date of birth
   - > Please tick the applicable situation
   - Day Month Year
   - Male
   - Female

1.5 Place of birth
1.6 Country of birth
1.7 Nationality
1.8 Home address
   - Street
   - Number
   - Postal code
   - Town

1.9 Civil status
   - > Please tick the applicable situation
   - unmarried
   - married
   - registered partnership
   - divorced
   - widow/widower

1.10 Details border-crossing document
   - Number
   - Country
   - Valid from (date)
   - Valid till (date)

1.11.1 Do you have a spouse or (registered) partner?
   - No > Go to 2 'Signing'
   - Spouse > Please complete the requested details below
   - (Registered) partner > Please complete the requested details below
HEALTH CERTIFICATE – ISS 2017

Must be completed in English when visiting the examining physician!

Personal information

<table>
<thead>
<tr>
<th>Family Name (Last Name)</th>
<th>Given Names (First &amp; Middle Names)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Country of citizenship

Sex

Age

Date of birth (DD – MM – YYYY)

At the ISS: Do you live on- or off-campus? On [ ] Off [ ]

Medical History

1. Does the patient suffer from any chronic illnesses? Yes [ ] No [ ]
   If yes, which? ________________________________

2. Has the patient had any serious allergic reaction(s) Yes [ ] No [ ]
   If yes, which? ________________________________

3. Regular medications: ____________________________________________________________________

Current State of Health

Conditions that would be necessary background information for providing healthcare on site:

Certification by physician

Printed name and official stamp of physician ________________________________

Place & Date ____________________ Signature ____________________________

Certification by student

I certify that I am aware of the ISS health insurance conditions stated on the website and that I have provided the examining physician with complete and accurate information regarding my physical and emotional condition.

Date & signature of student:

Place and date ____________________ Signature ____________________________
Malaria Contract Addendum (Africa)

This form is important. All Ghana, Senegal and Tanzania participants must sign this form.

Name (please print):

Program: ○ Ghana ○ Senegal ○ Tanzania

Term(s) – check all that apply: ○ Spring ○ Fall ○ Summer

Year(s) – check all that apply: ○ 2015 ○ 2016 ○ 2017 ○ Other: __________________________

Consent and Commitment to Utilization of Prophylactics against Malaria

Malaria is endemic in Ghana, Senegal and Tanzania. Unless malaria prophylactics are taken faithfully as prescribed there is a significant risk of contacting a serious or fatal disease. Consequently, CIEE will not accept you or retain you in this program if you do not agree to take anti-malaria medication as prescribed. The only exception to this rule is if you produce a statement from your doctor prior to the commencement of this program that, for other medical reasons, your doctor recommends against your taking any malaria prophylactic.

Please sign the form below and return it to us with your application materials.

I agree to take prophylactic anti-malaria medication regularly as prescribed unless prior to the beginning of the program, I submit to CIEE a statement from my doctor recommending against my taking said medication.

Signature of Participant

Date

Signature of parent of guardian of participant if participant is under the age of majority in the jurisdiction where this document is signed.

Date
CIEE – Supplemental Medical Release Form

This Medical Release form is supplemental and not in substitution of the CIEE Student Medical Form which I signed on or about ____________.

I am voluntarily opting to study abroad in Dakar, Senegal although I have disclosed that I have a serious allergy to peanuts. I understand that peanuts and/or their derivatives are used in virtually all Senegalese dishes. I agree to release CIEE from any liability for any medical issues or other problems that may result from this allergy during my time on the CIEE Dakar Language and Culture program. Further, I understand that CIEE will not be able to guarantee a peanut-free environment or peanut-free meals during my time on the program.

I understand that health issues stemming from my peanut allergy must not interfere with attendance in classes or with my participation in any CIEE obligatory and optional events and understand and accept that CIEE has the right to dismiss me from the program at any time if my allergy results in health issues or related problems that require significant on-going care by CIEE resident staff and my CIEE homestay family.

Student Name: __________________________

Student Signature: _______________________

Date: ______________ ___________________
MEDICAL EXAMINATION REPORT

For New Applicants:
1. The Medical Examination may be done in Singapore by any registered General Practitioner (GP). Applicants who are in their home countries/places of residence may have their Medical Examination and HIV test done in their home countries/places of residence at any medical clinic licensed to carry out such tests. If HIV testing is done in Singapore, it may be carried out with either rapid or ELISA tests.

For Renewal Applicants:
1. The Medical Examination MUST be done in Singapore by any registered GP. HIV testing may be done with either rapid or ELISA tests.

Notes for All:
1. This Medical Examination Report is to be completed by a registered doctor and returned to the examinee. The original copy of the laboratory report for HIV and the X-ray report must be attached to this Medical Examination Report only if the medical examination and testing is carried out overseas.
2. The laboratory report for HIV and the X-ray report submitted to the Immigration & Checkpoints Authority should be within THREE MONTHS from the date of the issue of the reports.

I Personal Particulars

1. Name (as in the passport):
2. Sex: M / F
3. Date of Birth:
4. Nationality:
5. Passport No.:
6. FIN No. (if applicable):
7. Address in Singapore:

II Medical Examination

I certify that the above-named has undergone a chest x-ray and the result of his/her chest X-ray is as indicated (with a [✓]/-):

1. TB (Chest X-ray)*
   Any evidence of active TB detected?
   
   [✓] Yes  [ ] No

   [*Pregnant Women are exempted from Chest X-Ray]

I certify that I have tested the above-named and the result of his/her HIV test is indicated below (with a tick [✓]).

2. HIV:
   
   [ ] Positive  [✓] Negative/Non-Reactive

Name of Examining Doctor (IN BLOCK LETTERS):
Signature: ____________________________
Clinic's Stamp & Address: ____________________________
Date: ____________________________
Telephone Number: ____________________________
MCR no: ____________________________

NOTE: For persons screened overseas, the name in the laboratory report for HIV and the X-ray report must be according to the name shown in the Passport.

DECLARATION

I, ____________________________ (name) declare that the above is not applicable to me as ____________________________ (pass type) on ____________________________ (dd/mm/yy) valid till ____________________________ (dd/mm/yy).

Signature & Date

** Those who were previously exempted from submitting the X-ray report because of pregnancy are required to submit a X-ray report certified by a Singapore registered GP, if you are not pregnant now.
*** Delete where necessary.

WARNING: IT IS AN OFFENCE UNDER THE IMMIGRATION ACT TO MAKE ANY FALSE STATEMENT, REPRESENTATION OR DECLARATION

Version 4 (4 Oct 07)
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REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HOME AFFAIRS
MEDICAL CERTIFICATE

CONDITIONS OF A RECURRENT NATURE
Although the person(s) may be generally in a good state of health at the time of the examination, it would be appreciated if the medical officer/practitioner could furnish details of any disease, condition or defect the person(s) has/have suffered and which might recur.

I hereby certify that I have examined the following person(s):

1. ........................................................................................................
2. ........................................................................................................
3. ........................................................................................................
4. ........................................................................................................
5. ........................................................................................................
6. ........................................................................................................
7. ........................................................................................................
8. ........................................................................................................

and find him/her/them—
(a) not mentally disordered* or physically defective in any way;
(b) not suffering from leprosy, venereal disease, trachoma, or other infections or contagious condition;
(c) generally in a good state of health;

except for the following defects observed:

Name of person(s) ................................................................................

Details regarding the disorder, disease or disability, the seriousness thereof and
the treatment, if any, prescribed/recommended

(Please type or print)

Official stamp and address of medical officer/practitioner/hospital

Signature of medical officer/practitioner ..................................................

Date ........................................................................................................

Int. code
250–299 All psychoses.
300 Neuroses.
301 Personality disorders.
303–304 Addictions.
308 Behaviour disturbances of childhood.
310–315 All forms of mental retardation.
320–349 Epilepsy and all other forms of degeneration of the central nervous system.

* "Mentally disordered" includes the following:
(1) A radiological report of the chest is required in respect of every prospective immigrant 12 years of age and over.

(2) The radiologist must insert the names of the prospective immigrants examined by him in the space provided for that purpose on the form. Unused spaces must be crossed out.

(3) A separate report is required in respect of every applicant suffering or suspected to be suffering from tuberculosis.

I hereby certify that I have radiologically examined the chest(s) of the following person(s) and that I could find no signs of active pulmonary tuberculosis.

Name:

(1) _____________________________________________

(2) _____________________________________________

(3) _____________________________________________

(4) _____________________________________________

(5) _____________________________________________

(6) _____________________________________________

______________________________________

Radiologist

Official stamp and address of Radiologist/Hospital:

Date: ________________________________________

______________________________________
Instructions for the NTU Health Exam for Incoming Exchange / Visiting Students

In order to understand the general health condition of incoming students, and to meet the regulations of National Taiwan University, all students should receive a health exam by a qualified physician. The registration procedure is not complete if the new student does not have her/his health exam form completed.

For convenience, you may take the health exam abroad, as long as all items are completed and the examination forms include the doctor’s signature and a stamp from the hospital or clinic (for certification), and is no longer than 3 months old.

You must print the “NTU Incoming Exchange / Visiting Students Health Exam Form” and the “Medical Examination Requirements for Students Applying for Short-Term Study in Taiwan (Form C)” as below appendixes and bring them to the hospital. The required items are included in the two forms. Most importantly, please remember to bring the completed exam form with you when registering at NTU.

※ Special instructions

1. Please inform the doctor if you are pregnant. (You are allowed to skip the CXR exam when you are pregnant.)
2. Please avoid checking your urine when menstruating.
3. Fasting at least for 8 hours is indicated for laboratory tests.
4. A physical exam by a physician and a Chest X-ray exam are mandatory items.
5. The Form C lists the medical examination requirements for students applying for short-term study in Taiwan. Students must provide information such as, the name of the vaccine, the date of the immunization, the name of the hospital or clinic, and the signature of the physician administering the vaccine, to the physician who fills in this form. If the student does not have measles or mumps IgG antibodies, at least one dose of MMR immunization is indicated to meet the medical examination requirements.
# 國立臺灣大學交換暨訪問學生健康檢查表

**NTU Incoming Exchange / Visiting Students Health Exam Form**

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Department</th>
<th>Nationality</th>
<th>Photo</th>
</tr>
</thead>
</table>

| Student ID | ARC or Passport No. | Birth Date | Year | Month | Day |
|------------|---------------------|------------|------|-------|

<table>
<thead>
<tr>
<th>Personal History</th>
</tr>
</thead>
</table>
| **Food allergies** or **Drug allergies** (Name | Item name: | )

<table>
<thead>
<tr>
<th>Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Height</strong> cm</td>
</tr>
<tr>
<td><strong>Waist circumference</strong> cm</td>
</tr>
<tr>
<td><strong>Pulse Rate</strong> /min</td>
</tr>
<tr>
<td><strong>Lungs</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral Cavity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uncorrected</strong> R</td>
</tr>
<tr>
<td><strong>Normal</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Right</strong></td>
</tr>
<tr>
<td><strong>Pass</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory Examinations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALT</strong>: U/L</td>
</tr>
<tr>
<td><strong>Creatinine</strong>: mg/dL</td>
</tr>
<tr>
<td><strong>T-cholesterol</strong>: mg/dL</td>
</tr>
<tr>
<td><strong>Protein</strong>:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments and Suggestions:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Muscles/Bones/Joints</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the student taking medications or treatment for any disease:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of health exam:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>License No.</th>
<th>Name of the medical institution for the health exam:</th>
</tr>
</thead>
</table>

*臺灣NTU (continued)*
Medical Examination Requirements for Students Applying for Short-Term Study in Taiwan (Form C)

**Basic data**

<table>
<thead>
<tr>
<th>姓名</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>性別</td>
<td>Gender</td>
</tr>
<tr>
<td>證件字號</td>
<td>ID No.</td>
</tr>
<tr>
<td>出生月日</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

**Medical Examination Requirements**

A. **Proof of Positive Antibodies or Immunization Certificates**

a. **Antibody Tests**

1. **Measles IgG antibody**

   - 阳性 Positive
   - 阴性 Negative

2. **Rubella IgG antibody**

   - 阳性 Positive
   - 阴性 Negative

b. **Immunization Certificate**

   - **Measles vaccine**
     - 第一剂：Date of the 1st immunization: ____(M) / ____ (D) / _____ (Y)
     - 第二剂：Date of the 2nd immunization: ____(M) / ____ (D) / _____ (Y)

   - **Rubella vaccine**
     - 第一剂：Date of the 1st immunization: ____(M) / ____ (D) / _____ (Y)
     - 第二剂：Date of the 2nd immunization: ____(M) / ____ (D) / _____ (Y)

   - **Others**
     - **Maternity Exemption**
     - **Tuberculosis Suspect**

b. **Availability of Immunization Certificates**

   - **Proof of Positive Antibodies or Immunization Certificates**

B. **X-ray Findings**

   - **Date of X-ray examination**: ____(M) / ____ (D) / _____ (Y)

   - **Results**
     - 合格(Passed)
     - 疑似肺结核(TB Suspect)
     - 必须进一步检查(Pending)
     - 不合格(Failed)
     - 孕妇免验(Maternity Exemption)

**Physician’s Comments and Suggestions**

According to the above medical reports, the student has passed the medical examination requirements.

- 合格 has met the medical examination requirements.
- 不合格 has failed the medical examination requirements.
- 需进一步检查 needs further examination.

**Physician’s signature**

Note: This form lists the medical examination requirements for students applying for short-term study in Taiwan. Students must provide information such as, the name of the vaccine, the date of the immunization, the name of the hospital or clinic, and the signature of the physician administering the vaccine, to the physician who fills in this form. If the student does not have measles or mumps IgG antibodies, at least one dose of MMR immunization is indicated to meet the medical examination requirements.
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ITEMS REQUIRED FOR HEALTH CERTIFICATE (Type B)

(Basic Data)

Name: ______________________ Sex: □ Male □ Female

ID No.: ______________________ Passport No.: ______________________

Date of Birth: __ / __ / ___ Nationality: ______________________

(Laboratory Examinations)

A. HIV (Serological Test for HIV Antibody): □阳性（Positive） □阴性（Negative）
   □未确定（Indeterminate）
   a. 藤检 (Screening Test): □ EIA □ Serodia □ 其他 (Others) ______________________
   b. 确认 (Confirmatory Test): □ Western Blot □ 其他 (Others) ______________________

B. 胸部 X 光检查（Chest X-Ray for Tuberculosis）: (妊娠婦女可免接受「胸部 X 光檢查」)
   □正常 (Normal) □ 异常 (Abnormal) ______________________
   □限大影 (Standard Film Only)
   C. 腹内寄生虫 (含囊类阿米巴等虫类) 粪便检查 (粪便及血液浓缩法检查) (Stool examination for parasites includes Entameba histolytica etc.) (centrifugal concentration method):
   □阳性 (Positive, Species) ______________________ □阴性 (Negative)

D. 梅毒血清检查（Serological Test for Syphilis）: □阳性（Positive） □阴性（Negative）
   a. □ RPR b. □ VDRL c. □TPHA/TPPA d. □ 其他 (Other) ______________________

E. 疫苗及预防接种证明 (Antibody test) 麻疹抗体 measles antibody titers □阳性 Positive □阴性 Negative
   德国麻疹抗体 rubella antibody titers □阳性 Positive □阴性 Negative
   □德國麻疹預防接種證明 Vaccination Certificate of Measles
   □德国麻疹预防接种证明 Vaccination Certificates of Rubella
   □预防接种证明 (Vaccination Certificates of Measles and Rubella vaccination certificates):
   a. 抗体检查 (Antibody test) 麻疹抗体 measles antibody titers □阳性 Positive □阴性 Negative
   德国麻疹抗体 rubella antibody titers □阳性 Positive □阴性 Negative
   b. 预防接种证明 Vaccination Certificates
   □预防接种证明 Vaccination Certificate of Measles
   □预防接种证明 Vaccination Certificates of Rubella
   c. □ 疫苗接种者，有接种禁忌者，暂时不适接种者 (Having contraindications, not suitable for vaccination)

汉生病检查 (EXAMINATION FOR HANSEN’S DISEASE)

皮肤病检查 (Skin Examination): □正常 Normal □异常 Abnormal (如果皮肤患区域不正常，须进一步检查)
   □有 (Yes) □无 (No)

备注(Note):

一、本表供外籍人士等申请在台湾定居或居留时使用，此形式为 for residence application.

二、儿童 6 岁以下必须到医院健康检查，但须具预防接种证明文件备查(年满 1 岁以上者，至少接种 1 剂麻疹、德國麻疹疫苗)。

三、妊娠妇妇及儿童 12 岁以下免受「胸部 X 光检查」。

四、儿童 15 岁以下免受「HIV 抗体检查」及「梅毒血清检查」。

五、居住在北美洲、欧洲、纽西兰、澳洲、日本、南韩、香港、澳门及新加坡等地区或国家之申请者，得免验肺内寄生虫粪便检查。
Result: According to the above medical report of Mr./Mrs./Ms. ______ , he/she has passed the examination.

Chief Medical Technologist: ___________________________  (Name & Signature)

Chief Physician: ___________________________  (Name & Signature)

Superintendent: ___________________________  (Name & Signature)

Date: ______ / ______ / ______  (Valid for Three Months)

Appendix: Principles in determining the health status failed

Test Item | Principles in determining the health status failed
--- | ---
Serological Test for HIV Antibody | 1. If the preliminary testing of the serological test for HIV antibody is positive for two consecutive times, confirmation testing by WB is required.
2. When findings of two consecutive WB testing (blood specimens collected at an interval of three months) are indeterminate, this item is considered qualified.

Chest X-ray | 1. Active pulmonary tuberculosis (including tuberculous pleurisy) is unqualified.
2. Non-active pulmonary tuberculosis including calcified pulmonary tuberculosis, calcified foci and enlargement of pleura, is considered qualified.

Stool Examination for Parasites | 1. By microscope examination, cases are determined unqualified if intestinal helminthes eggs or other protozoa such as Entamoeba histolytica, flagellates, ciliates and sporozoans are detected.
2. Blastocystis hominis and Amoeba protozoa such as Entamoeba hartmanni, Entamoeba coli, Endolimax nana, Iodamoeba butschlii, Dientamoeba fragilis found through microscope examination are considered qualified and no treatment is required.
3. Patients with positive result for parasites examination are considered qualified and please have medical treatment after delivery.

Serological Test for Syphilis | 1. After testing by either RPR or VDRL together with TPHA(TPPA), if cases meet one of the following situations are considered failing the examination.
   (1) Active syphilis: must fit the criterion (1) + (2) or only the criterion (3).
   (2) Inactive syphilis: only fit the criterion (2).
   2. Criterion:
   (1) Clinical symptoms with genital ulcers (chancres) or syphilis rash all over the body.
   (2) No past diagnosis of syphilis, a reactive nontreponemal test (i.e., VDRL or RPR), and TPHA(TPPA) = 1:320 (including 1:320)
   (3) A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.

Measles, Rubella | The item is considered unqualified if measles or rubella antibody is negative and no measles, rubella vaccination certificate is provided. Those who having contraindications, not suitable for vaccinations are considered qualified.
Malaria Contract Addendum (Africa)

This form is important. All Ghana, Senegal and Tanzania participants must sign this form.

Name (please print):

Program:  ○ Ghana  ○ Senegal  ○ Tanzania

Term(s) – check all that apply:  ○ Spring  ○ Fall  ○ Summer

Year(s) – check all that apply:  ○ 2015  ○ 2016  ○ 2017  ○ Other: ______________________

Consent and Commitment to Utilization of Prophylactics against Malaria

Malaria is endemic in Ghana, Senegal and Tanzania. Unless malaria prophylactics are taken faithfully as prescribed there is a significant risk of contracting a serious or fatal disease. Consequently, CIEE will not accept you or retain you in this program if you do not agree to take anti-malaria medication as prescribed. The only exception to this rule is if you produce a statement from your doctor prior to the commencement of this program that, for other medical reasons, your doctor recommends against your taking any malaria prophylactic.

Please sign the form below and return it to us with your application materials.

I agree to take prophylactic anti-malaria medication regularly as prescribed unless prior to the beginning of the program, I submit to CIEE a statement from my doctor recommending against my taking said medication.

Signature of Participant ______________________  Date ______________________

Signature of parent of guardian of participant if participant is under the age of majority in the jurisdiction where this document is signed ______________________  Date ______________________
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Natural Reserve System, University of California  
UCEAP Health Clearance Form

**REQUIREMENTS**

- Health care providers must be licensed and cannot be an immediate family member. *AMA Code of Ethics E-8.19*
- Health care providers must provide legible contact information.
- The student’s name and program information must appear on the form. Blank forms are not acceptable.
- The University of California may not approve a student’s participation in UCEAP/NRS unless a licensed health care provider certifies that the student is medically stable.
- The student must be assessed to participate in UCEAP/NRS by a health care provider and a specialist if the student is currently being treated by one.
- The student may be required to get a second clearance should there be a change in health history since the date of the initial clearance.

**STUDENT INSTRUCTIONS** – Also refer to your UC campus health clearance instructions.

This is a mandatory requirement. Your information is confidential and only shared on a need to know basis to facilitate assistance, particularly during an emergency. Deadline: No later than **60 days before course instruction begins**.

1. **Do not delay** in making your health clearance appointment. *Some campuses have limited appointments.* If you do not comply with this requirement, you may not be approved to participate in, or may be dismissed from UCEAP/NRS. **Even if your program allows a health clearance through a private physician, UCEAP/NRS reserve the right to require a clearance through the campus Student Health Center.**

2. **Complete the Confidential Health History form** (if your campus has online clearance procedures, ask your health center if you should follow them).

3. **Legibly write** your name, UC campus, program term, and year on the attached form before your appointment.

4. **Inform the UCEAP Systemwide Office** (UCEAP) of medical needs, accommodations, and/or changes in health that occur after the health clearance process. Failure to provide complete and accurate information may be grounds for non-participation in, or dismissal from, UCEAP/NRS.

5. **After your appointment, scan the original form and email it to NRS at CAecology@ucop.edu by the stipulated deadline.**

**HEALTH CARE PROVIDER INSTRUCTIONS**

1. The student must present to you a completed UCEAP Confidential Health History form. A physical examination is not needed unless required by the UC Student Health Center.

2. **Discuss/review the student’s health history** referring to the Confidential Health History form completed by the student and the student’s medical records on file.

3. **Focus on any condition requiring medication and/or continued treatment while abroad.**
   a. Students may be cleared for participation if:
      i. in the opinion of the examining health care provider and/or specialist any medical condition is under control,
      ii. they have a contracted treatment plan in place (if there is any evidence of recent physical/mental health treatment), for required and recommended care during the program, and
      iii. they have been stable on their medication for a reasonable period.
**STUDENT:** Print clearly with a ball point pen before appointment.

<table>
<thead>
<tr>
<th>First and Last Name of Student</th>
<th>UC Campus</th>
<th>NRS</th>
<th>Program</th>
<th>Term and Year</th>
</tr>
</thead>
</table>

HEALTH CARE PROVIDER must be licensed to practice and cannot be an immediate family member (AMA Code of Ethics E-8.19).

Only disclose information that is necessary and relevant to UCEAP’s duties.

I have reviewed the student’s Confidential Health History form and medical records on file. Based on the information provided to me by the student on the form, a review of the student’s personal health history, and knowing the student’s course involves seven weeks of continuous travel and field study in the California natural reserves, to the best of my knowledge, the student is:

### Licensed Psychotherapist or Licensed Specialist  
(Section & signature required if student is being treated by one.)

1. **CLEARED** (Check all that apply below)
   - 1.a No medical or psychiatric contraindications to UCEAP participation.
   - 1.b Student advised to arrange services to facilitate education. A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.

   - 1.c Student advised to arrange services to facilitate a healthy and safe stay during the program (e.g., regularly available psychiatric therapy, etc.) Indicate that student has treatment plan in place and is stable.

   - 1.d Student advised to carry a sufficient supply of medication to last through entire program. If on medication, please list.

   - 1.e List significant allergies (e.g., medication, food, etc.):

2. **NOT CLEARED:** There are medical or psychiatric contraindications to UCEAP participation.

### Licensed Physician or Health Care Provider (MD, DO, NP, RN, or PA)

1. **CLEARED** (Check all that apply below)
   - 1.a No medical or psychiatric contraindications to UCEAP participation.
   - 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.

   - 1.c Student advised to arrange services to facilitate a healthy and safe stay during the program (e.g., regularly available psychiatric therapy, etc.) Indicate that student has treatment plan in place and is stable.

   - 1.d Student advised to carry a sufficient supply of medication to last through entire program. If on medication, please list.

   - 1.e List significant allergies (e.g., medication, food, etc.): __________

2. **NOT CLEARED:** There are medical or psychiatric contraindications to UCEAP participation.

Upon completion, the student must scan the original form and email it to NRS at CAecology@ucop.edu by the stipulated deadline.