

## SYSTEMWIDE OFFICE

### Confidential Health History Form and Instructions for Students

**START THIS PROCESS EARLY.** Read carefully and complete the following form **before** your health clearance appointment.

- *The UCEAP Health Clearance is a participation requirement. It cannot be waived.* If you do not comply with all aspects of the UCEAP health clearance process, you may be dismissed from UCEAP. The original clearance is final unless the same doctor updates it.
- *Complete the confidential form accurately and truthfully before the health clearance consultation.* Failure to provide complete and accurate information to the health professional may be grounds for non-participation in UCEAP.
- *UCEAP strongly encourages you to fully disclose your health history, including pre-existing conditions, to the medical professional 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 participation in UCEAP. UCEAP can work with you to plan for your successful participation and to identify resources abroad.
- *You are responsible for notifying UCEAP immediately of any changes in your health before departure or while on the program.* UCEAP may require a second clearance or a letter from the treating physician indicating that you are stable to study abroad. Failure to disclose any health changes may be grounds for withdrawal.

**IF YOU HAVE A CHRONIC MEDICAL CONDITION,** know before departure how you will manage your condition abroad. Pre-existing conditions are often intensified by living in a different environment; there may be fewer, or inadequate, local resources to help you manage your condition as you do in the U.S. If you have a documented disability, contact your UC campus disability office for an accommodations letter **well before departure**. Follow protocols indicated on your program Pre-Departure Checklist (PDC).

#### For Students Traveling with Prescription Medication

1. Commonly prescribed medication in the U.S. could be unlicensed or prohibited in other countries. Verify that your medication is legal and that you can take a supply to last throughout your stay. Although medications in amounts for personal use generally are not inspected or questioned, some countries will not allow any amount of the medication, particularly if it contains controlled substances. In other countries, local Customs officials can become suspicious of medications in large quantities. Talk with your doctor if you need to switch medication. If your prescription medication contains a controlled substance, review medication regulations on official government websites. Check your UCEAP Program Guide for specific information. Also, web 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](http://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.** Always carry your prescription medications in original containers, and keep the letter from your physician handy. **Do not make plans to have refills mailed to you.**
3. You must be stable on your medication before departure. 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 (do not assume it will be available and/or prescribed by a local doctor), understand possible triggers, and know how to reach out for help, if needed.

#### General Health Clearance Instructions (may vary depending on your campus)

- FILL OUT** this form completely and honestly **before your health clearance appointment.**
- GIVE** a copy of this completed form to the health practitioner who performs your clearance.
- DISCUSS** your health history as well as information about physical and emotional challenges you may face while abroad with the health professional. Have contingency plans in case you need to seek care abroad.
- TAKE a copy** of your confidential health history form abroad to share with local health practitioners in case of a medical emergency. **Do not mail a copy to the UCEAP Systemwide Office.**

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

The UCEAP health clearance process 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 UCEAP. Your answers below and a review of your medical and 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 better plan for a successful and safe experience abroad.

**PRINT:**

Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex: M  F

Country/Program \_\_\_\_\_ Student I.D. \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_  
NAME PHONE, INCLUDE AREA CODE

**GENERAL HEALTH:**

List any recent or continuing health conditions: \_\_\_\_\_

List any physical or learning disabilities, and list any services you will need to facilitate your education: \_\_\_\_\_

Over the last 12 months have you been 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: \_\_\_\_\_

**MEDICATIONS: Student is responsible for ensuring that all medications are legal abroad.**

Are you currently taking any medications? Y  N  Specify name, type & brand of any medications including inhalers, bee sting kits, etc.

**MEDICAL HISTORY:** Students with medical condition(s) must prepare to manage them abroad. Complete below and provide details on back of form:

	Y	N	Date		Y	N	Date		Y	N	Date
Anemia or bleeding disorder				Ulcer/colitis				Back/joint problems			
Epilepsy/seizures				Hepatitis/gallbladder				High blood pressure			
Asthma/lung disease				Bladder/kidney problems				Thyroid problems			
Chronic headaches/migraines				Diabetes				Recurrent or chronic infectious diseases			
Heart disease				Cancer/tumors				Other (Note below)			

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

	Y	N	Please provide additional information for any 'Yes' response
Any mental health condition, including depression/anxiety			
Substance abuse (alcohol and/or drugs)			
Eating disorder (anorexia/bulimia/other)			
Are you taking/have ever taken medication for above?			

**IMMUNIZATION HISTORY:** Provide a copy of your immunization records as a supplement to this form –or– enter the dates you received the following vaccinations. Include dosage dates for numbered items and most recent vaccination date for non-numbered items:

Measles, Mumps, Rubella (MMR) #1 \_\_\_\_\_ #2 \_\_\_\_\_ -OR-  
 Measles (Rubeola): \_\_\_\_\_, Mumps: \_\_\_\_\_ and Rubella: \_\_\_\_\_  
 Tetanus-diphtheria-pertussis (Tdap): \_\_\_\_\_ -OR- Tetanus diphtheria (Td): \_\_\_\_\_  
 Varicella (Chickenpox) #1 \_\_\_\_\_ #2 \_\_\_\_\_ or History of chickenpox: \_\_\_\_\_  
 Polio 3-dose series: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ and Adult booster \_\_\_\_\_  
 Meningococcal conjugate (Serogroups A, C, Y, and W-135) \_\_\_\_\_ and/or (Serogroup B) \_\_\_\_\_  
 Hepatitis A #1 \_\_\_\_\_ #2 \_\_\_\_\_  
 Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 Human Papillomavirus (HPV) #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 Influenza (most recent) \_\_\_\_\_  
 Write type and most recent vaccination date of any vaccinations you have already received that may be relevant to your travel destination. E.g., Typhoid, Yellow Fever, Japanese Encephalitis, etc:

*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: \_\_\_\_\_