

SYSTEMWIDE OFFICE

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 risks 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 general practitioner.
- 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.*

University of California UCEAP Health Clearance Instructions for Private Health Care Providers

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.

GENERAL PRACTITIONER 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 right 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 before appointment.

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|-----------------------------------|---------------|-------------------|------|-------------------------------------|
| Student First and Last Name _____ | | | | UC Campus <input type="checkbox"/> |
| UCEAP Program Country/Countries | Program Title | Partner/Host Univ | Term | Multi-city <input type="checkbox"/> |

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:

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| <div style="background-color: #e0e0e0; padding: 5px; margin-bottom: 5px;">Licensed <u>SPECIALIST</u> or <u>PSYCHOTHERAPIST</u></div> <p><i>Section & signature <u>only</u> required if student is being treated by one.</i></p> <p>1. <input type="checkbox"/> CLEARED (Check all that apply below)</p> <p><input type="checkbox"/> 1.a No medical or psychiatric contraindications to UCEAP participation.</p> <p><input type="checkbox"/> 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.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> 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.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> 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.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> 1.e List significant allergies (e.g., medication, food, etc.):</p> <p>_____</p> <p>_____</p> <p><i>Complete notes on back of form if necessary.</i></p> <p>2. <input type="checkbox"/> NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.</p> <p>_____</p> <p>Licensed Specialist: <u>PRINT LEGIBLY name and title</u></p> <p>Signature: _____</p> <p>_____</p> <p>Date _____ Phone # _____</p> | <div style="background-color: #e0e0e0; padding: 5px; margin-bottom: 5px;">Licensed <u>GENERAL PRACTITIONER</u> (MD, DO, NP, RN, or PA)</div> <p><i>Section & signature required for <u>all</u> students.</i></p> <p>1. <input type="checkbox"/> CLEARED (Check all that apply below)</p> <p><input type="checkbox"/> 1.a No medical or psychiatric contraindications to UCEAP participation.</p> <p><input type="checkbox"/> 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.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> 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.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> 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.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> 1.e List significant allergies (e.g., medication, food, etc.):</p> <p>_____</p> <p>_____</p> <p><i>Complete notes on back of form if necessary.</i></p> <p>2. <input type="checkbox"/> NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.</p> <p>_____</p> <p>Licensed General Practitioner: <u>PRINT LEGIBLY name and title</u></p> <p>Signature: _____</p> <p>_____</p> <p>Date _____ Phone # _____</p> |
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Upon completion, keep one copy on file and give the original to the student to mail by the stipulated deadline to:

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

PRACTITIONER/CLINIC RUBBER STAMP OR BUSINESS CARD HERE: