UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Health Clearance Form

STUDENT: Complete top section clearly 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 only 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 Specialist: ***PRINT LEGIBLY name and title***

Signature: _____

Date _____ Phone # _____

Licensed GENERAL PRACTITIONER (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.
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Complete notes on back of form if necessary.

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

Licensed General Practitioner: ***PRINT LEGIBLY name and title***

Signature: _____

Date _____ Phone # _____

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

PRACTIONER/CLINIC RUBBER STAMP OR BUSINESS CARD HERE: