UC RIVERSIDE SUMMER STUDY ABROAD HEALTH CLEARANCE

ALL students must use this form to get their health clearance, regardless where the health clearance is obtained. It is a requirement to participate in the Summer Study Abroad Program. **THIS FORM IS TO BE USED IN CONJUNCTION WITH THE PERSONAL HEALTH HISTORY FORM AND HEALTH AND SPECIAL NEEDS QUESTIONNAIRE.**

UCR Summer Study Abroad Program, (951) 827-7739
http://SummerStudyAbroad.ucr.edu

HEALTH CLEARANCE FOR STUDENTS PLANNING TO STUDY ABROAD

INSTRUCTIONS

This form MUST be signed and returned to the following address on or before FRIDAY, May 16, 2014 and no later than thirty days BEFORE a student's departure.

University of California, Riverside
Undergraduate Education - Summer Study Abroad Office
900 University Avenue, Surge 325
Riverside, California 92521
951-827-7739

TO THE PHYSICIAN OR HEALTH PRACTITIONER:

The student named on the attached **Health Clearance form** has been tentatively selected to participate in UC Riverside's Summer Study Abroad Program. Students will spend a total of four weeks living and studying in a foreign environment during the summer months. This may create unexpected physical and emotional stress, which can exacerbate otherwise mild disorders. It is important that all participants be able to adjust to potentially dramatic changes in climate, diet, and living and studying conditions that may be seriously disruptive to accustomed patterns of behavior. Studying abroad does not provide an antidote to health problems experienced at home.

The health clearance is required for all UC students on Study Abroad. This clearance process must include the following steps:

1. **THE STUDENT MUST PRESENT TO YOU A FULLY COMPLETED STUDY ABROAD HEALTH HISTORY FORM.** Please review these forms carefully with the student for accuracy and completeness. You do not need to perform a physical examination unless required by the student's program, or the Campus Student Health Services office, but you must discuss/review the student's health history thoroughly, paying particular attention to immunizations that the student may need, any allergies the student may have, and all currently active health problems.

2. **PAY SPECIAL ATTENTION TO ANY EMOTIONAL OR PSYCHOLOGICAL PROBLEMS, AND ANY MEDICATIONS THE STUDENT IS TAKING.** Study Abroad is especially concerned for the well being of students who are anorexic or bulimic, and those who have bi-polar disorders, depression, or any other psychological health condition that require medication. These conditions may escalate to life-threatening levels in a foreign environment. Students may be cleared with these conditions provided they are in compliance with and stabilized on their medication.

3. **PLEASE IMPRESS ON THE STUDENT THEIR NEED TO TAKE A SUFFICIENT AMOUNT OF MEDICATION TO LAST FOR THE DURATION OF THE STUDY ABROAD PROGRAM OR ENSURE THAT THE MEDICATION IS LOCALLY AVAILABLE.** The physician may choose to have the student initialize consent on the attached form.

4. **THE MEDICATION IS LOCALLY AVAILABLE.** Please assess the need for any counseling or laboratory testing while abroad so Study Abroad can determine the availability of adequate facilities at the program site.

5. **PLEASE LIST ANY PHYSICAL OR LEARNING DISABILITIES THE STUDENT MAY HAVE, AND BE SURE TO NOTE THE FACILITIES OR SERVICES REQUIRED ABROAD ON THIS FORM.**

Students may be cleared for participation as long as, in the opinion of the examining practitioner, any medical conditions they may have is under control and they have been stabilized on their medication for a responsible period. **If a specialist is currently seeing the student for a serious ongoing medical or psychiatric condition, the specialist must also approve and sign this clearance form.**

AFTER EVALUATION OF THE STUDENTS HEALTH, PLEASE REVIEW & COMPLETE THE FOLLOWING PAGES.

UC Riverside Summer Study Abroad Program
University of California, Riverside

-PERSONAL HEALTH HISTORY FORM- PART I-

This form is **MANDATORY**. You may not participate in the UC Riverside Summer Study Abroad Program without submitting it.

INSTRUCTIONS: This is a medical **self-assessment**, to be completed **by you** to the best of your ability. Once you have completed this form, please sign it on page 3, and present it to your physician (or Campus Health Center). When mailing this information to our office, please mark your envelope **"CONFIDENTIAL**." Your information will be kept confidential. The information will be shared only with individuals who can administer medical attention to you in the event of a personal emergency while you are off campus on a Summer Study Abroad program. In most cases, it will be the only medical information used to assist you in case of an emergency abroad. Please be as thorough and disclosing as possible on the form and with your physician or healthcare provider, who will complete PART II and PART III. Parts I, II, and III should then be submitted to the UE Summer Study Abroad Office at UC Riverside.

GENERAL INFORMATION DOB: _____

_____ Sex F ☐ M ☐
(Last name) *(First)* *(Middle)*

Person to notify in case of emergency:

_____
(Name) *(Address)* *(Phone)*

UC RIVERSIDE STUDENT ID # _____ **OR**

HOME CAMPUS AND HOME CAMPUS STUDENT ID # _____

MY GENERAL HEALTH IS:

_____ Excellent _____ Good _____ Fair _____ Poor

HEALTH PROBLEMS
List any recent or continuing health problems:

_____

Check if you have ever had any of the following:

yes	no	date		yes	no	date		yes	no	date	
			anemia/bleeding disorder				high blood pressure				infectious mononucleosis
			asthma/hay fever/allergy				heart problem				thyroid problems
			back/joint problem				jaundice/hepatitis				psychiatric problems
			bladder/kidney problem				protein/sugar in urine				migraine headaches
			epilepsy/convulsion				ulcer/stomach problem				alcohol abuse
			cancer/tumors				anorexia/bulimia				substance abuse

yes	no	
		surgery _____

(Type) *(Year)*

DRUG ALLERGIES: Check any drug allergies and briefly describe what happened:

____ a. penicillin _____ ____ c. sulfa _____
____ b. novocaine/local anesthetic _____ ____ d. other _____
(specify)

IMMUNIZATION RECORDS: MANDATORY

Check and indicate most recent date:

____ Polio Immunization date _____
____ Meningococcal date _____
____ Tetanus Booster date _____
____ Yellow Fever date _____
____ Measles/Mumps/Rubella date _____
____ Hepatitis A date _____
____ Hepatitis B date _____
____ Varicella/Chicken Pox date _____
____ Typhoid date _____

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Participant Name (please print) **UCR Student ID** **Study Abroad Location/Dates**

-PERSONAL HEALTH HISTORY FORM- PART I-

TUBERCULOSIS Have you ever lived in close contact with anyone who had tuberculosis? ____ yes ____ no

Previous skin test: _____ negative _____ (year) _____ positive _____ (year) _____ never tested

TB medicine taken: _____

COMMUNICABLE DISEASES (give dates of treatment)

yes	No		Date of treatment
		TB	
		Syphilis	
		HIV/AIDS	
		Other (give details)	

ALLERGIES

Check if you have ever had an allergic reaction to any of the following:

yes	no	date		Describe your reaction:
			Penicillin	
			Novacaine/local anesthetic	
			Sulfa	
			Specify other drugs:	
			Peanuts (nuts)	
			Bee Stings	
			Aspirin	
			Eggs	
			Pollen (hay fever)	

MEDICINES

List any medications (pills or injections) you take regularly:

yes	no	daily		yes	no	daily		yes	no	daily	
			Antidepressant pills				Seizure medications				Inhalers
			Insulin injections/pump				Birth control pills				
			Other medications (name and reason for taking)								

DEVICES

yes	no	daily	
			Contact lenses or eyeglasses
			Hearing aid
			Prosthetic joints or devices (give details)

FAMILY MEDICAL HISTORY

	yes	no	who?		yes	no	who?
asthma/allergies				heart disease			
diabetes				high blood pressure			
				sickle cell			

MENTAL HEALTH TREATMENT

Have you been treated by a psychiatrist, psychoanalyst, psychologist, or therapist for any mental, emotional, or nervous disorder within the past 5 years? ☐ YES* ☐ NO

* If yes, please request a report from your from your psychiatrist or therapist (forms available in the Summer Study Abroad office). Turn in this report with these Health Screening Forms.

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Participant Name (please print) **UCR Student ID** **Study Abroad Location / Dates**

-PERSONAL HEALTH HISTORY FORM- PART I-

STATEMENT OF CONFIRMATION: The answers I have given are correct and complete to the best of my knowledge.

Signature of Student _____ Date _____

WAIVER: I understand and consent to the information on this form being released to the appropriate medical and Summer Sessions staff personnel abroad and state-side in case of a medical emergency. I hereby authorize the release of the information included on this form, including all pages of these Health Screening Forms and any additional medical information submitted to UC Riverside Summer Study Abroad (including verbal, electronic, and supplemental pages) to the University of California's employees, faculty, agents, or other designated official. I understand that this information will be used for the purpose of protecting my health during the period of my participation in the program identified on the form, or in the case of a medical urgency off campus.

Signature of Student _____ Date _____

AUTHORIZATION FOR MEDICAL TREATMENT:
Instructions: In the event of an emergency, UC Riverside will make every effort to reach the individual designated as an emergency contact before using the authorization below. However, in the case of an emergency, your authorization may assist in obtaining immediate and necessary medical care.

Statement: By signing this authorization, I hereby authorize the University of California's employees, faculty, agents, or other designated official to act on my behalf and authorize such emergency treatment to secure whatever treatment is deemed necessary.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision an upon the advice of or to be rendered by a physician and/or surgeon. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist.

Signature of Student _____ Date _____

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Participant Name (please print) **UCR Student ID** **Study Abroad Location/Dates**

-HEALTH SCREENING EXAMINATION- PART II AND PART III-

PART II – HEALTH SCREENING EXAMINATION – to be performed by a physician or healthcare provider

A standard medical screening should be documented in the clinic's official medical record only, and together with any medical reports submitted from outside consultants, is subject to standard policies governing release of confidential health data. Please refer to the instructions for an explanation of the purpose of the visit.

PART III – PHYSICIAN'S ADVISORY FORM – to be completed by physician or healthcare provider after reviewing PART I and reading/completing PART II (above).

The Physician or Healthcare Provider must complete the following information after reviewing the participant's Health Screening form with the participant. For participants seeing a specialist for a serious, ongoing condition, the approval of the specialist must be obtained prior to review by the Physician or Healthcare Provider.

The above-named student has been selected to participate in the UC Riverside Summer Study Abroad Program, offered through the Undergraduate Education Summer Study Abroad Programs at the University of California, Riverside. The student will spend four weeks traveling and studying abroad with the program. Living and studying in a foreign environment often creates unexpected emotional and physical stress which can exacerbate otherwise mild disorders. It is important that all participants be able to adjust to dramatic changes in climate, diet, living conditions and studying conditions that may be severely disruptive of accustomed patterns of behavior. Your candid evaluation of the student's health will be vital to our anticipating and dealing with any health problems that may arise during the student's stay.

After medical evaluation of the student named above, it is our opinion that:

☐ There are no medical contraindications to participation.

☐ The student should be advised against participation in the UC Riverside Summer Study Abroad Program.

In accordance with University of California Student Health Center guidelines, medical information which you feel should be made known to the Coordinator of the UE Summer Study Abroad Programs, or consulate, is listed below:

Signature of Physician or Health Practitioner _____

Date

_____

Medical Center Address Office Telephone Number

Please return this form to:

University of California, Riverside
Undergraduate Education
900 University Avenue, Surge 325
Riverside, CA 92521
Fax: 951-827-7745