UNIVERSITY of CALIFORNIA
Education Abroad Program

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 unless a licensed health care provider certifies that the student is medically stable.
- The student must be assessed to participate in UCEAP 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 departure** (except for Chile).

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. *Even if your program allows a health clearance through a private physician, UCEAP and/or the campus EAP Office 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, follow them).
3. **Legibly write** your name, UC campus, and UCEAP program name (country, host institution, and term), 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.
5. **After your appointment, return the completed and signed original and a copy** by the stipulated deadline to:
   UCEAP Systemwide Office, University of California, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117-5823

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 program or 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 while abroad, and
      iii. they have been stable on their medication for a reasonable period.
4. **Advise student to find out if their medication is locally available** or if there is an appropriate substitute.

University of California UCEAP Health Clearance Form

STUDENT: ***Print clearly with a ball point pen before appointment.***

First and Last Name of Student	*UC Campus*	*UCEAP Program Name* (**Country Host University Term**)

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 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 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 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 entire program (if allowed by customs). 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 Psychotherapist –or– Licensed Specialist (**PRINT LEGIBLY name and title)**	Phone number (include area code)

Signature:_____ Date: _____

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 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 entire program (if allowed by customs). 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/Health Provider: MD, DO, NP, RN, or PA (**PRINT LEGIBLY name and title)**	Phone number (include area code)

Signature:_____ Date: _____

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**.**

PHYSICIAN RUBBER STAMP OR BUSINESS CARD HERE