Health Screening Form (1 of 4)

UC San Diego Global Seminars
globalseminar.ucsd.edu

RIGORS OF STUDY ABROAD

ALL participants must complete this form to demonstrate they are cleared, health-wise, to participate in UC Global Seminars. The Health Clearance form must be signed and returned to the Programs Abroad Office, before the participant is allowed to participate in a UC San Diego Global Seminar program. Copies of the Medical History and Health Clearance forms are to be retained by both the healthcare professional and the participant as a confidential medical record.

TO THE PHYSICIAN/HEALTHCARE PROFESSIONAL:

The participant named on this Form is applying to participate in a program of study abroad. Students may spend from 5 to 10 weeks in residence abroad. Living and studying in a foreign environment may create unexpected physical and emotional stress, which may exacerbate otherwise mild disorders. It is important that all participants be able to adjust to potentially dramatic changes in climate, diet, living conditions and studying conditions that may be seriously disruptive to accustomed patterns of behavior. One should never assume that going abroad to study would provide an antidote to health problems experienced at home. Failure to disclose or inform UC San Diego Global Seminar and it's partners of medication or medical treatment potentially increases the risk the participant faces while studying abroad.

ALL PARTICIPANTS MUST BE GRANTED A HEALTH CLEARANCE TO STUDY ABROAD WITH UC SAN DIEGO GLOBAL SEMINARS

This clearance must include the following steps:

1. The participant must present you a fully completed Medical History form. Please review this form with the participant for accuracy and completeness. You do not need to perform a physical examination unless requested by the participant, but you must discuss the participant's health history thoroughly, paying particular attention to immunizations that may be needed, any allergies the participant may have, and all currently active health issues.

2. Pay special attention to any emotional/psychological problems and the medications the participant is taking. UC San Diego and it's partners are especially concerned for the well being of participants who have been diagnosed as anorexic or bulimic, bi-polar disorders or depression that requires medication; these conditions may increase the risk to life-threatening levels in a foreign environment. Participants may be cleared with these conditions provided they are in compliance with and stabilized on their medication.

3. Please impress on the participant the need to ascertain the availability of medications in the country to which they are traveling and/or assure that they have a supply of any necessary medication sufficient to last for the entire period they will be abroad. The need for any counseling or laboratory testing while abroad should also be disclosed so that UC San Diego Global Seminars may determine the availability of adequate facilities at the program site.

4. Please describe any physical or learning disabilities the participant may have. Please note that students requesting ADA accommodation must register with UC San Diego Office For Student with Disabilities and must contact the UC San Diego Global Seminars Coordinator.

Participants may be cleared for participation so long as, in the opinion of the examining healthcare professional, any condition they may have is under control and they have been stabilized on their medication for a reasonable period of time. If a specialist for a serious ongoing medical or psychiatric condition is currently seeing the participant, the specialist should also approve and sign this clearance form.

Health Screening Form (2 of 4)

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Last Name:_____ First Name: _____

Birth Date MM/DD/YY: _____ Gender:_____PID:_____

Program: (include all countries where you plan to travel)_____

INSTRUCTIONS TO THE STUDENT:
Please complete the general health survey questions in PART I below to the best of your ability, sign, and submit this form to the examining physician or health care provider, who will complete PART II and PART III. **If you are using University Health Services please make your appointment 4-6 weeks prior to the date you would like it.** Parts I, II, and III should then be submitted to the PAO Office **together by March 1, 2013.**

PART I: GENERAL HEALTH (check off or circle items that apply)

My general health is: Excellent☐ Good☐ Fair☐ Poor☐

Allergies: Penicillin: ☐ Aspirin: ☐ Bee stings: ☐
Peanuts: ☐ Eggs: ☐ Pollen: ☐
Other (give details)_____

Diet: Regular: ☐ Vegetarian: ☐ Restricted (give details): _____

Medications: Vitamin pills ☐ Birth Control ☐ Seizure Medications ☐
Antidepressant pills ☐ Inhalers ☐ Insulin injections/pump ☐
Other medications prescribed for medical or mental health conditions (give details)_____
_____

Devices: Contact lenses or eyeglasses ☐ Hearing aid R☐ L☐
Prosthetic joints or devices (give details)_____
Other (give details)_____

Medical history: Surgery (give dates and type) _____
Hospitalization (give dates and type) _____

Communicable diseases (give dates of treatment): TB_____ Syphilis____ HIV/AIDS____ Other_____

Other serious health considerations:

	Yes	No
Asthma	☐	☐
Cancer/tumors	☐	☐
Anorexia/Bulimia	☐	☐
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Alcohol or other substance abuse	☐	☐
Ulcer/stomach problem	☐	☐
Bladder/kidney problem	☐	☐
Back/joint problems	☐	☐
Anemia or bleeding disorder	☐	☐
Hepatitis/jaundice	☐	☐
Migraine headaches	☐	☐
Thyroid problems	☐	☐
Other_____	☐	☐

Health Screening Form (3 of 4)

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Last Name:_____ First Name: _____

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, your mental health care provider must clear you for travel by signing on the bottom of the last page in the space labeled "signature of specialist or psychotherapist".*

Immunization Record:

Indicate **the date** of your last immunization for each item. A copy of your records may be available from your high shool or health care provider. Students are advised to carry a copy of their official immunization record while traveling. An international vaccination/innoculation immunization record can be obtained from the UC San Diego Student Health services center should you choose to see a travel nurse and have any such vaccinations/innoculations.

Typhoid	_____	Meningococcal	_____
Polio Immunization	_____	Varicella/Chicken Pox	_____
Tetanus Booster	_____	Hepatitis A	_____
Measles/Mumps/Rubella	_____	Hepatitis B	_____
Yellow Fever (For certain countries only)	_____		

Reasonable Accommodation Request:

PAO and Global Seminars are committed to providing services to students with disabilities who are eligible for reasonable accommodation under the Section 504 of the Rehabilitation Act or the Americans with Disabilities Act. If you choose not to disclose, PAO will not be able to assist you in arranging disability-related accommodations upon your arrival.
Do you anticipate requiring disability related accomodation(s) while abroad? Yes☐ No☐

If yes, please attach the reasonable accommodation request form available at the Programs Abroad Office. The reasonable accommodation form must be completed with the Office for Students with Disabilities (858-534-4382) confirming the disability and information about any accommodations they provide.

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

_____

Signature of Student Date

RELEASE OF INFORMATION: I understand that the information included on all pages of the Post-Selection Health Screening form and any additional medical information submitted to the UC San Diego Global Seminars may be shared with employees, faculty, agents, or other designated officials 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 emergency abroad.

_____

Signature of Student Date

Health Screening Form (4 of 4)

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PART II: HEALTH SCREENING EXAMINATION:
(to be completed by the physician or health care provider)

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

NOTE: It is our policy not to accept reports completed by parent-physicians.

PART III: MEDICAL ASSESSMENT:
(to be completed by the physician or health care provider after reviewing PART I and completing PART II)

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

Name of Student (please print) PID # Global Seminar Name

I have read the attached information about the rigors of study abroad and reviewed the student's Health Screening form with the student. Based upon the information provided to me by the student on the Health Screening form, and pursuant to a review of of the student's personal health history, I find:

_____ **There are NO medical or psychiatric contraindications to participation** and the student is cleared to study abroad.

_____ **While the student is conditionally cleared to study abroad,** *the student should arrange the following in advance of Global Seminar participation:* 1. Services that would facilitate the student's education (e.g., note taking, wheel chair access).
Student should contact the Disability Resource Center.

2. Services that would facilitate a healthy and safe stay (e.g., regularly available psychiatric therapy, allergy treatment, etc.) Student should contact Psychological and Counseling services or other resources as needed. Indicate significant resolved psychiatric history.

3. Take a sufficient amount of medication to last for the duration of the program or ensure that the medication is locally available. Indicate if significant allergy to any medication.

_____ **There ARE medical contraindications to participation** and in my judgment the student is NOT cleared to study abroad.

_____ **There ARE psychiatric contraindications to paticipation** and in my judgment the student is NOT cleared to study abroad.

PRINT name of physician/health Signature of physican/health care provider Date Telephone Number

PRINT name of specialist/psychotherapist (if needed) Signature of specialist Date Telephone Number