Non-EAP Travel Program Health Clearance Form

STUDENT: Complete top section clearly with a ballpoint pen before appointment.

_____
Student First and Last Name

_____
Program Country/Countries Program Title Term

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 UCSC'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 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 UCSC Study Abroad 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 UCSC Study Abroad 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 UCSC Study Abroad 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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   - ☐ 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 UCSC Study Abroad 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:

UCSC Division of Global Engagement, Classroom Unit 101
1156 High Street, Santa Cruz CA 95064

PRACTIONER/CLINIC RUBBER STAMP OR BUSINESS CARD HERE: