UCEAP
UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

UCEAP 2023 Annual Health Update

Country-Specific Health Requirements

Summer 2023 – Spring 2024 Programs

Released January 26, 2023

Contacts

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2023 Annual Update of UCEAP Program-Specific Health Requirements

Updates are announced via email. For questions, email IHSCM@uceap.universityofcalifornia.edu

Directory

Summary of New Changes

Country/Host Health Requirements	Russia removed for 23-24 academic year
Country/Host Health Requirements	Solomon Islands removed for 23-24 academic year
Korea	Updated info on Korea, SNU, and Yonsei health forms for on-campus living
Lyra and Wellness Agreement	Information on mental health services available to all UCEAP students and our new approach to health clearances with special conditions
Japan	Osaka University no longer requires health form

COUNTRY AND HOST UNIVERSITY HEALTH REQUIREMENTS

Argentina
Australia
Barbados
Belgium
Botswana
Brazil
Canada
Chile
China
Costa Rica
Czech Republic
Denmark
Dominican Republic
France
Germany
Ghana
Hong Kong
Iceland
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Israel
Italy
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Korea
Mexico
Morocco
Multi-City - London/Paris
Multi-City - Mexico City/Sacramento, CA
Multi-City - Buenos Aires/Santiago
Multi-City - Florence/Syracuse/Barcelona
Netherlands
New Zealand
Norway
Singapore
South Africa
Spain
Sweden
Switzerland
Taiwan
Thailand
UK - England and Scotland
USA - Natural Reserve System

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COUNTRY AND HOST UNIVERSITY SAMPLE HEALTH FORMS

Barbados

Belgium

Botswana

China

Ghana

Israel Hebrew University
Technion

Japan Doshisha
ICU academic year
Keio
Meiji Gakuin

Korea

Netherlands

Singapore

South Africa

Taiwan

USA Natural Reserve System

Definitions and Other Information

UCEAP Confidential Health History Form (See Appendix for sample and instructions)

Most UC campus Student Health Services (SHS) use online patient portals to collect students' confidential health history before the health clearance review. Students do not send a copy to UCEAP.

UCEAP Health Clearance Form (See Appendix for samples and instructions)

UCEAP requires that students going to Botswana, Ghana, India, Solomon Islands, and South Africa complete their health clearance at their UC SHS. For all other countries, UCEAP defers to Student Health for whether they will allow students to complete the health clearance through an outside provider. Some SHS provide a screen print of the Encounter screen from their PnC system in place of using the health clearance form.

If students have changes to their health status that occur between the date of the initial health clearance and the start of the program, they must notify UCEAP. Students may be required to obtain a second health clearance or statement from the treating physician indicating the student is stable to participate.

Program-Specific Medical forms (See Appendix for samples)

Some programs require additional medical forms, as listed in the country-specific section. Samples of forms are for use as reference only. UCEAP sends official forms to students with instructions to bring forms to their appointment.

UCEAP Health and Safety Course

Anyone with UC credentials can access the course: https://learn.uceap.universityofcalifornia.edu/

All students are required to complete the UCEAP Health and Safety Course. They receive instructions to access the course through their UCEAP Portal. The course is comprised of two parts. The first part includes four modules that cover general health and safety information applicable to all students. The second part includes modules for countries with elevated endemic disease risks: Argentina, Barbados, Botswana, Brazil, Chile (Socio-ecological sustainability in southern Chile program only), China, Costa Rica, Dominican Rep., Ghana, India, Jordan, Mexico, Morocco, Russia, Solomon Isl., South Africa, and Thailand. Only students going to these countries take this second part of the course.

Student Travel Insurance

All students are automatically covered by student travel insurance while abroad. Direct students to the Insurance tab in their UCEAP Portal for additional information.

Benefits start 14 days before the official start of the UCEAP program, and end 14 days after the official end of the UCEAP program.

It does not cover preventive care, including vaccinations and physical exams. The exception is for Malaria prophylaxis. Malaria prophylaxis is covered if:

1) it is prescribed by a licensed practitioner and filled, picked up, and paid for within the term of coverage (no more than 14 days before the official start of the UCEAP program), and
2) is a necessary prescription in relation to the student's UCEAP program. Student must submit a claim for refund consideration.

If the student has UCSHIP coverage, they can consult with the campus insurance office whether the prophylaxis is covered so they do not have to pay up front and submit a reimbursement request.

Through the student travel insurance, students have access to Chubb-AXA Global Travel Assistance, also known as AXA Assistance. AXA Assistance provides medical referrals to local doctors, virtual/video medical appointments (aka teleconsultation), behavioral health crisis consult, medical and billing case management if admitted to a hospital, and arrangements for medical evacuation if deemed necessary. Through AXA Assistance, students can schedule virtual appointments through a mobile app called Dr. Please.

Medication Information UCEAP Shares with Students Before Departure

Prescription Medications:

The student is responsible for researching whether their medications are legal and locally available in their program country. UCEAP cannot maintain a list of medications and their legality for all countries. UCEAP emails all students roughly two months before the start of their program with general information about things they need to consider if traveling with prescriptions. Students are also directed to read about travelling with prescription medication in the Health chapter of the UCEAP Guide to Study Abroad.

Students can review medication regulations on the International Narcotics Board (INCB) website and official local-country government sites for medications containing controlled substances (including amphetamine-based medications). INCB provides excerpted national statutes for most countries.

Mailing Medications:

Students cannot mail medication abroad. The USPS and many countries have strict laws against private individuals mailing medications, including oral contraceptives and vitamins. In the US, prescription medications can only be mailed by Drug Enforcement Administration (DEA) registered entities. Similar regulations may apply to over-the-counter medications.

Psychological Health

Depending on the location, UCEAP Study Centers and host institutions abroad can connect students with English-speaking mental health counselors. Some countries have limited mental health support services, and/or English-speaking medical practitioners. Some students benefit from a treatment plan while abroad. Once abroad, students have access to Lyra, a mental health service provider (see Lyra Global Services below). Students can also access the Chubb-AXA Behavioral Crisis Consult service.

Students with Disabilities

All students must be registered with the campus disability office before departure, even if they believe they will not need accommodations abroad. Accommodations requested after departure cannot be facilitated if the campus Disability Office cannot provide an accommodations letter.

Wellness Agreement

UCEAP will be using a new approach to Health Clearances that include special conditions. In addition to referring the student to services and support to manage their health and wellness, we will be using a Wellness Agreement for significant conditions. If a Health Clearance includes a letter detailing significant requirements in order to participate, UCEAP will place those requirements in a Wellness Agreement and work with the student to schedule appointments in advance of their arrival in country. Significant requirements examples are specific therapy with specified time limits between appointments, medication monitoring, and/or regularly scheduled specialist appointments for an ongoing condition.

The Wellness Agreement also requires the student to agree to the following clauses:

- I agree that my health and safety is paramount and that if recommended by my treatment team, I will return to the United States and withdraw from the program. If I choose not to do so, I may be placed on UCEAP probation, or I may be dismissed from the program.
- I understand that the purpose of this contract is to address concerns regarding my safe participation on the program and to reasonably facilitate my participation in UCEAP's Program. This is a binding contract, and all parties to it understand that if I do not fulfill my responsibilities fully as outlined in the contract and in a timely manner, I may receive disciplinary action.
- I understand that the spirit of this letter is in caring for my wellbeing and academic success, and that I will need to partner with health professionals to successfully manage my condition and learn strategies for self-care while in in my program country.

Any questions regarding the Wellness Agreement or to discuss Conditions on a Health Clearance, please contact: ihscm@uceap.universityofcalifornia.edu

Lyra Global Services

UCEAP has partnered with UC SHIP to offer Global Mental Health Services with the same provider as UC SHIP domestic services, Lyra Health. Students do not have to be enrolled in UC SHIP to access Global Services as a UCEAP student. All UCEAP students are automatically enrolled in Lyra Global Services during their program dates.

Lyra is different from other mental health services; it uses a combination of counselors, clinicians, technology, and research-backed therapies to develop personalized treatment plans. Students can connect with Lyra in person, via video or by phone and access a robust library of DIY content.

Lyra allows all UCEAP students to participate in up to 20 mental health counseling sessions for no additional fee. This is different from our travel insurance program where students pay up front for services and then request reimbursement by submitting a claim. No paperwork, no fees required for Lyra; simply sign up and attend the counseling session. If more than 20 sessions are needed during program participation, Lyra will work with the travel insurance at session 19 to transfer the billing without disrupting the treatment program. This will allow students to continue seeing the same therapist during their program term. Coverage begins on the student's program start date and ends at the program end date. Students can only access Lyra Global Services while outside of the United States.

For any questions regarding Lyra Global Services, please contact: ihscm@uceap.universityofcalifornia.edu

ARGENTINA

Required by Government: -0- *Required by Host University:* -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course

Important Considerations:

- **YF RISK** – Students can participate in an optional field trip to Iguazu Falls in the subtropical Argentine province of Misiones (far northeastern corner of the country), where there is risk of yellow fever.

AUSTRALIA

Required by Government:

When applying for the mandatory student visa, an electronic application process, some students may be required by the Australian Department of Home Affairs to undergo a medical exam and chest X-ray. ***This happens rarely***, but if it does the Australian embassy gives students instructions to download the required medical forms. These forms must be completed by a physician and returned to the Australian embassy in Washington, D.C.

Required by Host University: -0-

Important Considerations:

- **FIELDTRIPS - Marine Biology & Terrestrial Ecology** – This program includes required field activities of moderate physical intensity, primarily hiking. Student should not have serious conditions that require on-going medical supervision affecting their ability to participate safely in these field activities. Participants must be able to take care of their own medical needs without impacting teaching, fieldwork schedules, or other students.

BARBADOS

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: Original, signed Univ. of the West Indies Confidential Medical Questionnaire (*see Appendix*). Student is responsible for submitting the form to the Univ. of West Indies campus International Office.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

BELGIUM

Required by Government:

FYI ONLY: The Belgian Government requires that students submit a medical certificate with their student visa application. The doctor's signature must be notarized by a notary public. The student must then get the documented authenticated by apostille, which is obtained from the Secretary of State where the notary public has their office. The medical document can be issued a maximum 3 months before the date of application.

It may be difficult or impossible for health centers to provide the above service. This is FYI ONLY in case students inquire.

Required by Host University: -0-

BOTSWANA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by CIEE: 1- Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Malaria prophylactic pills—all students must sign a Malaria Prophylaxis Participation Agreement (*see Appendix*) and purchase antimalarials before leaving the US (*See Pg. 4 'UCEAP Travel Insurance' for coverage details that apply to antimalarial medication.)*
2. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **MALARIA -** Students must consistently take antimalarials throughout the entirety of the program, and follow personal protective practices to prevent mosquito bites.
    - Before getting a prescription for antimalarials, students should disclose all medical conditions and other medications to a prescribing doctor**.** Lariam and Mefloquine may not be suitable for people with a history of depression, anxiety, or other mental illnesses

BRAZIL

Required by Government: -0- *Required by Host University*: COVID-19 vaccination proof, YFI

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course

Important Considerations:

- **CARNIVAL -** Discuss with students any relevant health risks associated with attendance at large-scale events. Many students will attend Carnival (Feb. 17-25, 2023).
- **YF RISK -** In response to the outbreak that began in early 2017, the World Health Organization has expanded the list of areas where yellow fever vaccination is recommended for international travelers to include Brazil. Yellow fever vaccination should be considered for all students participating in UCEAP programs in Brazil.

CANADA

Required by Government: -0- *Required by Host University*: -0-

CHILE

Required by Government:

Chile has two consulates in California, located in San Francisco and Los Angeles. Students must apply for their visa at the consulate closest to their UC campus. The consulates have different health clearance timing requirements, as follows:

- The consulate in Los Angeles requires that the health clearance be completed and signed 30 days *or fewer* before the visa application.
- The consulate in San Francisco requires that the health clearance be completed within six months of the visa application. Despite this flexibility, UCEAP recommends that the clearance be done within three months of the visa appointment.

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Both Chilean consulates require:

- The **original, manually-completed** UCEAP Health Clearance form (*see Appendix for sample form*) **signed by an MD** whether an FNP, NP or PA performs the clearance.
    - The doctor's name *and* title must be clearly and carefully printed on the form, along with contact information including phone number, address, and e-mail address.
    - The form must bear the official stamp of the medical facility for each physician signing the form. A validation stamp or business card will suffice.

  Forms that *do not* conform to this requirement will be returned, which will delay the visa process.

Required by Host University: -0-

Important Considerations for programs in Santiago:

- **AIR POLLUTION -** Santiago can have severe air pollution, especially during the winter months of May–August. Students with respiratory conditions should prepare for an increase in symptoms.

Required by UCEAP and the UCEAP Physician Consultant for Social Sustainability in Southern Chile program only:

1. Successful completion of the UCEAP Health and Safety Course

Important Considerations for Socioecological Sustainability in Southern Chile (Fall) program:

- **HEIGHTENED PHYSICAL AND MENTAL DEMANDS** - The Socioecological Sustainability in Southern Chile (SSSC) program exposes students to a wide range of ecosystems as they travel from one area of Southern Chile to another.
    - Students spend 12 weeks in Villarrica with several trips to National Parks. Environments include mountains, riverine, volcanic, forest, and lake. Research projects involve forests, fields, rivers, animals or insects, and take place during the day and after dark.
    - Students participate in strenuous outdoor activities (e.g., camping and hiking).
    - Students complete a mandatory 8-hour safety workshop in Villarrica to learn basic first aid and outdoor safety skills.
    - Students receive instruction outdoors and live in close quarters in biological field stations.
    - Students must be able to manage well within a group.
- **LIMITED ACCESS TO MEDICAL AND MENTAL HEALTH SERVICES** - Although reliable medical services are available in Southern Chile, students will be conducting field research in rural and/or remote environments.
    - Remote locations may be hours from medical facilities.
    - Communication and transportation are difficult at some National Parks, and evacuations and medical care may be delayed.

CHINA

Required by Government for all programs in China:

YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Government for students who will be in China for more than six months:

- *If a student is participating in back-to-back programs in China, they should contact the UCEAP International Proram Specialist, Ashley Arvanites, at aarvanites@uceap.universityofcalifornia.edu to find out if their program combination will exceed six months and if they will need to complete the Physical Examination Record for Foreigners.*
- Students (except Chinese citizens) who will be in China for more than six months are required to apply to extend their residency within 30 days of their arrival in China. This includes students in the Peking University (PKU) Year program and some students in back-to-back programs at different Chinese universities.
- A thoroughly completed and properly stamped *Physical Examination Record for Foreigner* (*see Appendix for notated sample form*) must be submitted with the residency extension application.
- Each student required to apply for extension of residency has the option to complete the physical exam and the required lab work in the US as part of the UCEAP Health Clearance process –**or**– to wait until after arrival in Beijing. Factors for the student to consider include:
    - Time frame: The exam and lab tests must be completed no more than six months prior to the student's registration date in China; otherwise, it will be considered invalid.
    - Potential costs associated with the exam: Students will pay approx. $60 (US) to have the exam done in Beijing. Students who have the exam done in the US will pay the exam cost in the US (varies by physician and insurance) plus an additional $10 (US) to have the results verified by the Beijing Physical Exam Facility, operated by the National Quarantine Bureau. If the form and lab results are not accepted for any reason (this can be arbitrary), the student will pay to have the exam re-done.
    - Potential costs associated with the exam results: Students who return positive test results for diseases listed on the form may not be granted a residency extension and may be required to leave China.

Use the following instructions and the notated sample form in the Appendix if a student requests to have the physical exam done at Student Health Services (SHS):

PHYSICAL EXAMINATION RECORD FOR FOREIGNERS - INSTRUCTIONS:

1. Students must use the form provided to them by UCEAP (*See Appendix for notated sample form*).
2. Complete all boxes; do not leave any section blank.
3. All original lab exam results attached to the form (e.g., blood tests, X-rays) must be clear and specific and bear the official* stamp of the laboratory completing the exam. Do not submit lab results marked, "COPY." Students will be required to retake tests if lab results are illegible or improperly stamped.

   **If no other stamp is available, use an address stamp that includes the name of the UC SHS or lab.*

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4. Follow detailed instructions on notated sample form (see Appendix).
5. Use metric measurement units where indicated.
6. If health indicators listed on the bottom half of Pg. 1 (e.g. development, nourishment, skin, nose) are within normal ranges, write "normal" in each box.

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7. If test results are negative, write "negative."
8. Write Chest X-ray results in the box indicated and attach the original, stamped lab report. Original X-ray films are not required.
9. Attach original TB lab results (stamped by UC SHS or lab). Students with active TB will not be allowed into China.
   - A positive TB skin test requires negative chest X-ray results.
   - Original chest X-ray films are not required, but a printed report is required.
10. Write ECG results in the box indicated and attach the original printout results (stamped by UC SHS or lab).
11. Clearly label and write test results for HIV and Syphilis in the box indicated.
    - The original blood test reports must be included for both AIDS and Syphilis. The Chinese government will not accept a photocopy of the HIV test result.
    - All results must be clearly marked as negative, or another health exam may be required.
12. Write "None found" in the box labeled "None of the following diseases or disorders found during the present examination" unless evidence of one of the listed diseases was, in fact, found.
13. Write "None" if you have no suggestions for the student.
14. Sign and date where indicated.
15. Stamp both pages of the *Physical Examination Record for Foreigner* with the official stamp of the UC SHS or private physician completing the form:
    - on the student's photo on Pg. 1, and
    - near the physician's signature on Pg. 2.

Required by Host University: -0-

*Required by CIEE for **Summer Global Internship Program***: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **AIR POLLUTION -** Air pollution is common in all major cities, especially during winter as a result of burning coal for heat. Sensitive individuals should avoid prolonged or heavy outdoor exertion. All others should keep prolonged or heavy outdoor exertion to a minimum.
- **LIMITED MENTAL HEALTH SERVICES -** Treatment facilities are underdeveloped. There is a lack of trained mental health professionals, high stigma among the population, and lack of effective public mental health care. Official policy disallows primary health care professionals to independently diagnose and treat mental disorders within the primary care system.

  Students with pre-existing conditions will need a treatment plan indicating when and to whom to contact for help.

COSTA RICA

Tropical Biology Programs (Monteverde Fall and Spring)

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **HEIGHTENED PHYSICAL AND MENTAL DEMANDS -** Physically demanding field activities are a major component of the program.
  - Activities include camping, hiking, snorkeling, and backpacking through mountainous tropical forests.
  - Research projects involve forests, fields, ocean, streams, animals or insects, and take place during the day and night in remote locations. Students may be at times conducting research on their own.
  - Students must be able to manage well within a group.
- **LIMITED ACCESS TO MEDICAL AND MENTAL HEALTH SERVICES -** Students will be in a rural, remote environment.
  - Although reliable medical services are available throughout Costa Rica, students will be living in a rural, tropical environment.
  - Program activities occur in remote places that may be many days from medical facilities.
  - Communication and transportation are difficult. Medical care/evacuation may be significantly delayed.

  Transportation to medical facilities from some locations may require:

  - Thirty minutes by boat and another 30 minutes by car to get to a clinic for stabilization. If necessary, student would be transported to a major hospital near San Jose by car or plane/helicopter.
  - Student would walk, get taken out by horseback or carried on a rescue board to the Monteverde Cloud Forest Reserve (14 km - at best 3 hours or so by horse). From there, student would be taken to a clinic in Monteverde (10 minutes), evaluated, treated, stabilized, and possibly evacuated to San Jose (3.5 hours).

CZECH REPUBLIC

Required by Government: -0-

Required by Host University: -0-

Required by CIEE: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

DENMARK

Required by Government: -0-

Required by Host University: -0-

DOMINICAN REPUBLIC

Required by Government: -0-

Required by Host University: -0-

Required by CIEE: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

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DOMINICAN REPUBLIC *continued*

Important Considerations:

- **MALARIA** - Students spend six weeks in Santiago followed by one week living in a homestay and monitoring patient care at a health clinic in a rural community, where Malaria transmission rates may be higher.
    - Before getting a prescription for antimalarials, students should disclose all medical conditions and other medications to a prescribing doctor. Lariam and Mefloquine may not be suitable for people with a history of depression, anxiety, or other mental illnesses.

FRANCE

Required by Government: -0-

Required by Host University: -0-

GERMANY

Required by Government: -0-

Required by Host University: -0-

Required by CIEE for Global Summer Internship program: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

GHANA

Required by Government: Yellow Fever Innoculation required for students arriving *from all countries*. The International Certificate of Vaccination should be affixed to the visa inside of the student's passport and presented at the port of entry in Ghana.

Required by Host University: Malaria prophylactic pills—all students must sign a Malaria Prophylaxis Participation Agreement (*see Appendix*) and purchase antimalarials before leaving the US.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **MALARIA** - Students must take antimalarials consistently throughout the entirety of the program, and follow personal protective practices to prevent mosquito bites.
    - Prescribing antimalarials - the program length for the summer is 6 weeks, and fall/spring is 5 months. Before getting a prescription for antimalarials, students should disclose all medical conditions and other medications to a prescribing doctor. Lariam and Mefloquine may not be suitable for people with a history of depression, anxiety, or other mental illnesses.
- **SUN SAFETY -** Sun block is recommended throughout the year, even if traveling during their winter months. In summer, a hat and sunglasses are strongly recommended.
- **COMMUNITY SERVICE** - Students may participate in community service and volunteer opportunities that may put them at additional risk due to working in school or health settings.

HONG KONG

Required by Government: Covid-19 full vaccination and booster

Required by Host University:

CUHK requires students to complete an online confidential health history form. It does not require special medical tests or physician signatures.

HKU and **HKUST** have no university health forms.

ICELAND

Required by Government: -0-

Required by Host University: -0-

INDIA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host Universities: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **AIR POLLUTION -** Air pollution is common in New Delhi and Mumbai, among many other cities. Students with respiratory conditions should prepare for an increase in symptoms.
- **RABIES –** Due to the amount of stray dogs throughout country, there is significant risk. Discuss bite avoidance and pre-exposure immunization. The UCEAP travel insurance does not cover the cost of pre-exposure immunizations.

IRELAND

Required by Government: -0-

Required by Host University: -0-

Important Considerations

- **ACADEMIC INTENSITY** – **Dublin Summer Physics and Dublin Summer Chemistry, University College Dublin** are fast-paced with a rigorous schedule. Weekly academic activities may include up to 8 hours of teaching sessions, 9 hours of labs, 6 hours of workshops, and 25 hours of self-study. You will have weekly exams and homework sets. Due to the intensive nature of the program, it is not possible to make changes to timetables or reschedule assessments.

ISRAEL

Required by Government: -0-

Required by Host University:

Hebrew University: Complete physical examination. *Hebrew University Report of Medical Examination* must be completed and results of any lab work noted on the form (*see Appendix*).

Israel Institute of Technology, Technion/Neubauer: Student must complete the *Student Health Declaration Form* (*see Appendix*). This form *does not* have to be signed by a medical practitioner.

ITALY

Required by Government: -0-

Required by Host University: Covid-19 full vaccination required for all programs

JAPAN

Required by Government: -0-

Required by Host University: Certain host universities require a health form. See Appendix for samples as a reference only. Student is responsible for bringing correct form. The form changes often and university staff will not accept old forms.

Japanese health form required:

- Doshisha University
- International Christian University (ICU) fall/year/spring only
- Keio University
- Meiji Gakuin University

Japanese health form not required:

- Hitotsubashi University
- Osaka University
- Tohoku University
- University of Tokyo
- Waseda University

Frequently Asked Questions:

1. Will ICU accept titer results for vaccination proof? **YES**
2. ICU requires either a negative tuberculin skin test or a negative CXR. Would a negative Quantiferon Gold test (the relatively new blood test for tuberculosis that rules out false positive skin tests) also be acceptable? **Yes, a NEGATIVE Quantiferon Gold Test is acceptable**
3. Is the ICU Health Form required for students participating in the summer program at ICU? **NO, it is only required for students in fall, year, or spring programs.**

Important Considerations:

- **MENTAL HEALTH SERVICES –** English-speaking counselors may be available at International Christian University, Meiji Gakuin University, Doshisha University, Osaka University, Tohoku University, and Waseda University, but there is no guarantee. Resources may not exist outside of Tokyo, especially in rural areas.
- **TRAVELING WITH MEDICATION -** Japan has strict rules and stiff penalties regarding importation of prescription medications. A "Yakkan Shoumei" Certificate is required. Students should determine if their medication is legal in Japan by checking the US Embassy in Japan website for more information, or by contacting the local Japan consulate.

JORDAN

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by CIEE: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

KOREA

Required by Government: -0-

Required by Host University:

- **Yonsei** - *TB test results on a medical report*. Students who will live in the on-campus dorms (SK Global House or International House) must submit TB test results upon arrival in order to check into the dorm. The test must be done within 2 months of the dorm move-in date. There is no actual form (students can refer to the UCEAP Yonsei Housing Instructions in their UCEAP Portal). Due to the 60-day requirement, these students will require a separate appointment to obtain the TB test.
- **Seoul National University** - *Chest X-ray for TB, and Measles Vaccination report*. Students who will live in the on-campus Gwanak Residence Halls or Global Residence Halls must submit the chest x-ray and measles report upon arrival to check into the dorm. The test must be done within 6 months of the dorm move-in date. There is no actual form (students can refer to the SNU Housing Instructions in their UCEAP Portal). The tests can be written in Korean or English, and must include the doctor's signature, official seal of hospital, issue date, and hospital address.
- **Korea University** - *TB test results*. Students who are assigned on-campus housing will be required to take a tuberculosis test (x-ray, blood test, or skin test) dating after July 1st for fall semester and January 1st for spring semester. The certificate must be issued in Korean or English only. The TB test result should be submitted to the dormitory upon check-in.
  Incoming Exchange/Visiting Students Health Certificate Form (*see Appendix)*. Students must upload their completed Health Certificate form to their KU Online Application. The examination must be completed within 2 months from the start of the KU application period and the form must be signed by a healthcare professional (physician/doctor only). Exam timeframe guidelines:
  - The health form must be completed between February and April for Fall and Year programs.
  - The health form must be completed between August and October for the Spring program.

MEXICO

Required by Government:

Students who are required to apply for a visa from the Mexican Consulate (year students and some non-US citizens) may ask for a *statement of good health*. This can be a photocopy of the signed UCEAP Health Clearance form, or a signed letter on official letterhead stating that the student is in good health.

Required by Host University:

National Autonomous University of Mexico: Covid-19 full vaccination

Global Health in Mexico: Covid-19 full vaccination, exemptions will not be considered

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **AIR POLLUTION** - Students with respiratory conditions should prepare for an increase in symptoms.

MOROCCO

Required by Government: -0- *Required by Host University*: -0-

Required by CIEE: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **AIR POLLUTION -** Students respiratory conditions should prepare for an increase in symptoms due to particulate matter and hot air from desert climate.

MULTI-CITY PROGRAM - Global Cities Urban Realities: London/Paris

Required by Government: -0- *Required by Host University*: -0-

Required by Accent Global Learning: Covid-19 full vaccination

MULTI-CITY PROGRAM - Leadership in Social Justice and Public Policy: Mexico City/UC Sacramento, CA

Required by Government: -0- *Required by Host University*: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course

Important Considerations:

- **AIR POLLUTION -** Students with respiratory conditions should prepare for an increase in symptoms.

MULTI-CITY PROGRAM - Human Rights & Cultural Memory: Buenos Aires/Santiago

Required by Government: -0- *Required by Host University*: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

MULTI-CITY PROGRAM - Mediterranean Politics, Food & Culture: Florence/Syracuse/Barcelona

Required by Government: -0- *Required by Host University*: Covid-19 full vaccination

NETHERLANDS

Required by Government: -0- *Required by Host University:* -0-

Optional TB Test - Students may be required to complete an "Intent to undergo a TB test" form (*see Appendix for sample*) as part of the application process for a residence permit. Students are not required to get a TB test prior to arrival in the Netherlands, and US citizens are generally not required to get a TB test at all. Some students may choose to get a TB test, but this is not a requirement and no physician signature is required.

NEW ZEALAND

Required by Government: -0- *Required by Host University:* -0-

NORWAY

Required by Government: -0- *Required by Host University*: -0-

SINGAPORE

Required by Government:

1. YFI, if arriving from or transiting for more than 12 hours through countries with YF transmission risk.
2. The *Medical Examination Report* is required for students studying in Singapore for more than six months (i.e. academic year participants only). Students must use the official form identified by the partner university. Instructions and a link to the form will be available in their admission packet (*see Appendix for sample form*).
    - The *Medical Examination Report* is required by, and will be submitted to, the Singapore Immigration & Security Checkpoints Authority to issue certain immigration documents after arrival.
    - An HIV test and TB chest X-ray are required components of the medical examination. The original copies of the laboratory reports must be attached to the *Medical Examination Report*.
    - Laboratory reports must be in English and be printed on official clinic forms or letterhead. The reports must include the student's full name and date of birth.
    - The *Medical Examination Report* should be completed in the US no more than three months prior to the student's registration date in Singapore; otherwise, it will be considered invalid.
    - The *Medical Examination Report* can be completed in Singapore. The cost to complete the process at National University of Singapore is about SGD 60. The cost to complete the process at Singapore University of Technology and Design is TBD. However, waiting to complete the *Medical Examination Report* in Singapore could result in a delay with receiving the Student Pass required to participate in the program.

3. Student Pass holders (visa) must be fully vaccinated against COVID-19 at least two weeks before arrival in Singapore.

Required by Host University:

- Singapore University of Technology and Design requires all students to be fully vaccinated against COVID-19 to participate on the program. UC deferrals or exceptions will not be accepted.
- The National University of Singapore requires all students to be fully vaccinated against COVID-19 to participate on the program. UC deferrals or exceptions will not be accepted.

*Required by CIEE for **Global Summer Internship Program***: COVID-19 full vaccination.

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Important Considerations:

- **FIELDTRIPS**
    - The National University of Singapore Biodiversity Summer program includes a required weeklong field research trip to Pulau Tioman, a tropical island off the East coast of Malaysia. Student must be able to participate in all field trip activities, including light-to-moderate physical intensity. Student should not have serious conditions that require on-going medical supervision affecting their ability to participate safely in the fieldtrip. Student must be able to take care of their own medical needs without impacting teaching, fieldwork schedules, or other students. The nearest medical facility is only accessible either on foot, quadricycle, or speedboat.

SOUTH AFRICA

Required by South African Consulate for visa (do not submit to UCEAP):

1. Medical Certificate (form DHA-811), one page (*see Appendix*).
2. Radiological Report (form DHA-806), one page. Skin TB test is acceptable to attach in lieu of Radiological Report (chest X-ray). Either the results of a TB test or an X-ray report are required to submit to the consulate in order to obtain a student visa (*see Appendix*).
3. YFI, if arriving from or transiting through countries with YF transmission risk.

NOTE: Medical and TB test results (above) must not be older than 6 months at the time of visa application at the Los Angeles Consulate.

Required by Host University: -0-

*Required by CIEE for **Summer Global Internship Program***: Covid-19 full vaccination

The CIEE Physician's Medical Report is **not** required for students studying in CIEE programs through UCEAP.

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Important Considerations:

- **HIV/AIDS -** HIV/AIDS is estimated to be present in 19% of the adult population (*Source:* Travax). South Africa has the largest antiretroviral therapy program in the world, but also has the world's largest epidemic, so access to treatment is limited.
- **SUN SAFETY -** Sun block is recommended throughout the year, even during the winter months. In summer, a hat and sunglasses are strongly recommended.

SPAIN

Required by Government for students who will be in Spain for more than six months: An original medical certificate meeting the following requirements:

- It must be printed on the medical facility's letterhead.
- It must be signed by a physician (MD or DO). Stamped signatures are not acceptable.
- It must bear the official stamp of the administering medical facility *in addition to* the doctor's signature.
- It must be issued in the place of the student's residence.
- It must contain the required text in both English and Spanish, and each version must be signed and dated by the physician.

Required text:

This medical certificate attests that Mr. / Ms. [*student's name as it appears on their passport*] does not suffer from any illness that would pose a threat to public health according to the International Health Regulations of 2005. Signature Date
Este certificado médico acredita que el Sr./Srta [*student's name as it appears on their passport*] no padece ninguna de las enfermedades que pueden tener repercusiones graves a la salud pública, en conformidad con lo dispuesto en el Reglamento Sanitario Internacional del 2005. Firma Fecha

The doctor must certify that the student does not suffer from any illness that would pose a threat to public health according to WHO IHR 2005. This includes, but is not necessarily limited to: **Small pox, SARS, Human Influenza caused by a new subtype, Poliomyelitis due to wild type poliovirus.**

Continued on next page…

SPAIN *continued*

- Any amendment to the certificate or erasure may render it invalid.
- The certificate is valid for three months from the issue date.

Students may be required to get a medical evaluation after arrival in Spain for visa renewal.

Required by Host University: -0-

SWEDEN

Required by Government: -0-

Required by Host University: -0-

SWITZERLAND

Required by Government: -0-

Required by Host University: -0-

TAIWAN

Required by Government: Year students ONLY will submit a supplemental health certificate (*see Appendix*) with their residence visa application. They are advised to do this after their arrival.

Required by Host University:

National Taiwan University (Summer): -0-

National Taiwan University (Fall/Year/Spring): *Incoming Exchange/Visiting Students Health Exam Form* and *Medical Examination Requirements for Students Applying for Short-Term Study in Taiwan (Form C),* including chest X-ray results (s*ee Appendix).*

Form C lists the medical examination requirements for students applying for study in Taiwan. Students must provide information such as the name of the vaccine, the date of the immunization, the name of the hospital or clinic, and the signature of the physician administering the vaccine, to the physician who fills in this form. If the student does not have measles or mumps IgG antibodies, at least one dose of MMR immunization is indicated to meet the medical examination requirements.

All labs listed on the form (physical examination, laboratory examinations, immunization records, and chest x-ray) are mandatory items and not valid without the medical institution's seal and physician's signature.

Chest X-ray films *do not* need to be submitted to UCEAP or the host university.

Refer to the notated sample forms in the appendix.

Students must submit the form in person to the NTU Office of International Affairs during the onsite registration.

The physical exam must be completed and form signed by a healthcare professional. Physical exam timeframe guidelines:

- The health exam must be completed after July 1 for Fall and Year programs.
- The health exam must be completed after November 30 for the Spring program.
- These must be completed no more than 3 months prior to program start date.

THAILAND

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: Covid-19 full vaccination and booster

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP Health and Safety Course.

Continued on next page…

THAILAND *continued*

Important Considerations:

- **FIELDTRIPS -** The International Economics Summer program requires a 1–2-week field trip to a neighboring country. Past locations include Burma (Myanmar), Cambodia, Laos, and Vietnam. Summer 2023 students are scheduled to visit four cities in Vietnam: Ho Chi Min City, Mui Ne, Dalat, and Nha Trang. Student must be able to take care of their own medical needs without impacting the program.
- **AIR POLLUTION -** Air quality, particularly in Bangkok and Chiang Mai, have at times risen to unhealthy levels.
- **ALLERGIES -** The cuisine commonly includes ingredients that can cause anaphylaxis.
- **HIV/AIDS -** Thailand has one of the highest numbers of reported AIDS cases in Southeast Asia.

UNITED KINGDOM – *England and Scotland*

Required by Government: -0- *Required by Host University*: -0-

Required by Accent Global Learning: Covid-19 full vaccination

Important Considerations

- **ACADEMIC INTENSITY**
  - **Sussex Summer Physics** at University of Sussex is an 8 week summer programs covering a year's worth of material. This intensive, fast-paced program focuses on physics for life sciences. Weekly academic activities may include up to 8 hours of teaching sessions, 6 hours of labs, 6 hours of workshops, and 25 hours of self-study. Students have an exam every other week and a quiz in every workshop. Due to the intensive nature of the programs, it is not possible to make changes to timetables or reschedule assessments.
  - **Glasgow Summer Physics** at the University of Glasgow is fast-paced with a rigorous schedule. Weekly academic activities may include up to 8 hours of teaching sessions, 6 hours of labs, 10 hours of workshops, and 12 hours of self-study. Due to the intensive nature of the programs, it is not possible to make changes to timetables or reschedule assessments.
- **VACCINATIONS** - Group C meningococcal vaccination may be required after arrival by some host universities.

UNITED STATES – NATURAL RESERVE SYSTEM

California Ecology and Conservation (Summer, Fall, Winter, Spring)

Required by Government: -0- *Required by Host University*: -0-

Required by UCEAP:

1. Completion of the NRS Health Forms.

Important Considerations:

- **HEIGHTENED PHYSICAL AND MENTAL DEMANDS** - The Natural Reserve System ("NRS"): California Ecology and Conservation program exposes students to a wide range of state ecosystems as they travel from one reserve in the UC Natural Reserve System to another.
  - Students spend 7 weeks at Natural Reserves in California. Environments include mountains, desert, coast, and island. Research projects involve forests, fields, ocean, streams, animals or insects, and take place during the day and after dark.
  - Students participate in strenuous outdoor activities in remote locations (e.g., camping and hiking).
  - Students receive instruction outdoors and live in close quarters in biological field stations.
  - Students must be able to manage well within a group.

- **LIMITED ACCESS TO MEDICAL AND MENTAL HEALTH SERVICES** - Students live in rural and/or remote environments.
  - Remote locations may be hours from medical facilities.
  - Communication and transportation are difficult at some Natural Reserves, and evacuations and medical care may be delayed.

UCEAP
UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Appendix

Sample UCEAP & UC Campus Health Clearance Forms

2023 Annual Health Update

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Confidential Health History Form and Health Clearance Form Instructions

For programs in **Botswana**, **Ghana**, **India**, **Solomon Islands**, or **South Africa**, you must be cleared through your UC campus Student Health. For all other countries, refer to your campus Student Health to check if you have the option of going through a private physician.

Schedule an appointment with your doctor, specialists (if applicable), and a travel health clinic if recommended by your doctor. See your specialist(s) before you see your general practitioner. This appointment is to discuss medication and treatment plans during your program abroad, and to obtain your providers' signatures indicating you are cleared to participate. *We cannot waive this requirement. All information is confidential and may only be shared with UCEAP officials in an emergency. Failure to provide complete and accurate information may be grounds for non-participation in UCEAP.*

Before Your Appointment(s):

1. Fill out the Confidential Health History Form, and the top portion and vaccine compliance section of the health clearance.
2. Complete the required Health and Safety Course, linked in your UCEAP Portal.
3. Review the Health chapter of the Guide to Study Abroad linked in your UCEAP Portal.
4. Research medication legality if you will be traveling with prescription medication.

Students with Disabilities: If you have a documented disability or other chronic systemic condition, contact your campus EAP office and your UC campus Disabled Students Office (DSO). A letter on letterhead from your campus DSO must be sent to UCEAP indicating your UC accommodations. See Request for Disability Accommodation Abroad, under requirements in your UCEAP Portal.

In light of varying conditions and services available, universities abroad may require this letter with sufficient notice for a request for accommodations to be evaluated. Students who disclose needs at the last minute, or who require accommodations that cannot be made available in the host country, may be advised to postpone participation or consider another site. (NH2019)

During Your Appointment(s):

1. Give the Confidential Health History Form to your providers and discuss the following:
    a. Any pre-existing conditions, even if under control. Your doctor/specialist can advise and discuss possible continued treatment plans in support of your participation in UCEAP. UCEAP can help you identify resources abroad.
    b. Environmental or programmatic factors that may affect chronic health conditions.
    c. Prescription medication legality and if you need to switch to a different medication.
    d. A contingency plan for flare-ups or medical emergencies.
2. Ask for a letter from your physician on letterhead, explaining diagnosis, treatment, and prescription regimen, as you may need this for customs and it can facilitate continued treatment abroad.
3. Show your treating doctor(s) and specialist(s) the below Provider Notes section.

Instructions for Providers (students may have additional forms required by host university/country):

- Review the student's Confidential Health History Form and/or health history on file.
- Consider student's stability of medical conditions, compliance, and treatment plan if needed.
- Discuss medication or treatment availability in the host country.
- Consider environmental or programmatic factors that may affect chronic conditions.
- If student is seeing a specialist, the general practitioner should review any specialist notes.
- Sign the form under the appropriate box (general practitioner or specialist).

Submitting Forms

- Submit Completed Health Clearance form by either eFax or email by the stipulated deadline in your UCEAP Portal:
    - **eFax**: (805) 893 3021 *This is a secure, HIPAA-compliant eFax portal.*
    - **Email**: healthclearance@uceap.universityofcalifornia.edu
      NOTE: Using non-encrypted email to send your completed health clearance is not private or secure. Also, there is a possibility that the email could be intercepted and read by others whom you did not intend to receive it.
- Take your Confidential Health History form with you abroad for personal reference—do not submit this form to UCEAP.
- If there are any changes to your health after submitting the health clearance form, you must notify UCEAP. You may be required to submit an updated health clearance or treating doctor's letter.

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Confidential Health History Form

DO NOT SEND A COPY OF THIS FORM TO YOUR CAMPUS EAP OFFICE OR TO THE UCEAP SYSTEMWIDE OFFICE

The UCEAP health clearance process must be completed 60 days before the official program start date (except for Chile, refer to your UCEAP Portal). *It is a non-waivable requirement.* Your answers below and a review of your health records on file will be used during the health clearance process. *You must inform UCEAP or your UC campus SHS of any recent medical or special needs or changes in health that occur before the start of the program.*

Complete this form before your medical appointment. Failure to provide complete and accurate information may be grounds for non-participation in UCEAP. Your confidential disclosure can help you and the clinician to better plan for a successful and safe experience abroad.

PRINT:

Last name _____ First _____ Middle _____ Sex: M ☐ F ☐

Country/Program _____ Student I.D. _____

Person to notify in case of emergency: _____ _____
NAME PHONE, INCLUDE AREA CODE

GENERAL HEALTH: List any recent or continuing health conditions: _____

List any physical or learning disabilities, and list any services you will need to facilitate your education: _____

_____

Over the last 12 months have you been under the care of a doctor or other health care professional, including mental health treatment? Yes ☐ No ☐

Doctor's Name: _____ Phone/Fax: _____

Address: _____

For what condition(s): _____

SURGERIES: List type and year _____

_____

DRUG/FOOD ALLERGIES: List any drug or food allergies and briefly describe reaction: _____

_____

MEDICATIONS: Student is responsible for ensuring that all medications are legal abroad.

Are you currently taking any medications? **Y** ☐ **N** ☐ Specify name, type & brand of any medications including inhalers, bee sting kits, etc.

_____

MEDICAL HISTORY: Students with medical condition(s) must prepare to manage them abroad. Complete below and provide details on back of form:

	Y	N	Date		Y	N	Date		Y	N	Date
Anemia or bleeding disorder				Ulcer/colitis				Back/joint problems			
Epilepsy/seizures				Hepatitis/gallbladder				High blood pressure			
Asthma/lung disease				Bladder/kidney problems				Thyroid problems			
Chronic headaches/ migraines				Diabetes				Recurrent or chronic infectious diseases			
Heart disease				Cancer/tumors				Other (Note below)			

MENTAL HEALTH HISTORY: Have you ever been diagnosed, been treated for, or been hospitalized for any of the following?

	Y	N	Please provide additional information for any 'Yes' response
Any mental health condition, including depression/anxiety			
Substance abuse (alcohol and/or drugs)			
Eating disorder (anorexia/bulimia/other)			
Are you taking/have ever taken medication for above?			

IMMUNIZATION HISTORY: Provide a copy of your immunization records as a supplement to this form –or– enter the dates you received the following vaccinations. Include dosage dates for numbered items and most recent vaccination date for non-numbered items:

☐ Check box if you already submitted vaccination documentation [MMR, VZV, Tdap, MenACWY and TB screening] to campus Student Health.

☐ Check box if you have a medical exemption on file with campus Student Health, and write 'Exempt' in place of vaccination dates below.

Measles, Mumps, Rubella (MMR) #1_____ #2_____ -OR-

Measles (Rubeola): _____, Mumps: _____ and Rubella: _____

Tetanus-diphtheria-pertussis (Tdap):_____ -OR- Tetanus diphtheria (Td):_____

Varicella (Chickenpox) #1_____ #2_____ or History of chickenpox _____

Tetanus-Diphtheria-Pertussis (Tdap): _____

Polio 3-dose series: #1_____ #2_____ #3_____ and Adult booster _____

Meningococcal conjugate (Serogroups A, C, Y, and W-135) _____ and/or (Serogroup B) _____

Hepatitis A #1_____ #2_____

Hepatitis B #1_____ #2_____ #3_____

Human Papillomavirus (HPV) #1_____ #2_____ #3_____

Influenza (most recent)_____

On back of form write type and most recent vaccination date of any vaccinations you have already received that may be relevant to your travel destination. E.g., Typhoid, Yellow Fever, Japanese Encephalitis

I certify that all responses made on this form are complete, true and accurate. I understand that if there are any changes in my health status, I will contact UCEAP immediately. I understand that if I withhold information on this form I may be withdrawn from the program.

Student's Signature: _____ Date: _____

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Health Clearance Form

Student First and Last Name | UC Campus

UCEAP Program Country/Countries | Program Title | Partner/Host University | 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 self-reported health history and available medical records. Based on the information provided to me by the student, a review of their available medical records, specialist recommendations provided (if applicable), and knowledge of the student's UCEAP program destination, to the best of my knowledge, the student is:

Licensed SPECIALIST or PSYCHOTHERAPIST
Section and 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)
     - ☐ Student has a treatment plan.
     - ☐ Student 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).
   - ☐ 1.e Additional details attached in a separate letter regarding student's condition.

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

Licensed Specialist: *Print name and credentials*

Signature:

Date: Phone number:

Licensed GENERAL PRACTITIONER (MD, DO, NP, RN, or PA)
Section and 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.
   - ☐ 1.c Student strongly advised to continue treatment abroad. (e.g., counseling, medical monitoring)
     - ☐ Student has a treatment plan.
     - ☐ Student 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).
   - ☐ 1.e Additional details attached in a separate letter regarding student's condition.

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

Licensed General Practitioner: *Print name and credentials*

Signature:

Date: Phone number:

CLEARING PRACTITIONER RUBBER STAMP OR BUSINESS CARD HERE:

STUDENT– Indicate the following: I am compliant with the UC COVID-19 Policy Vaccine Mandate by either being fully vaccinated as defined by my UC campus, OR receiving a UC Approved Exception or Deferral:

☐ **Yes** ☐ **No**

Submit completed form by either eFax or email by the deadline stipulated in the UCEAP Portal.

eFax (805) 893 3021 *This is a secure, HIPAA-compliant eFax portal.*

Email **healthclearance@uceap.universityofcalifornia.edu**
NOTE: Using non-encrypted email to send your completed health clearance is not private or secure. Also, there is a possibility that the email could be intercepted and read by others whom you did not intend to receive it.

Sample UC Berkeley Clearance

UNIVERSITY HEALTH SERVICES
Tang Center

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

EAP Health Clearance Form

Student's name: ,
ID#:
UC Campus: UCB
UC EAP Program Country/Countries: United Kingdom
Program Title: English Universities
Partner/Host University: King's College London
Term: Fall 2021
Multi City:

I have reviewed the student's self-reported health history and available medical records. Based on the information provided to me by the student, a review of their available medical records, specialist recommendations provided (if applicable), and knowledge of the student's UCEAP program destination, to the best of my knowledge, the student is:

CLEARED (select all applicable options below)

[X] No medical or psychiatric contraindications UCEAP participation.

[ ] 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.

[ ] Student strongly advised to continue treatment abroad (e.g., counseling, medical monitoring, etc.). Indicate that student has treatment plan in place and is
stable.

[ ] 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).

NOT CLEARED: [ ]

There are medical or psychiatric contraindications to UCEAP participation

Provider: Melanie Deal NP

Sample UC Davis Health Clearance

UNIVERSITY OF CALIFORNIA, DAVIS

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

COWELL STUDENT HEALTH CENTER

ONE SHIELDS AVENUE
DAVIS, CALIFORNIA 95616-8711

12/12/2022 8:47 AM

Re: SID#

EAP Program: Sciences Po Reims, France

I have reviewed ***'s*** Confidential Health History form and medical records on file. Based on the information provided to me by the student on the Confidential Health History form, and pursuant to a review of the student's personal health history, to the best of my knowledge, the student is:

Cleared with no medical or psychiatric contraindications to EAP participation.

William Yeaton, MD

Sample UCLA Health Clearance

, Acct #: DOB: Age: yrs Sex:
10/20/2022 9:56 AM with WARE, JESSICA RN for HEALTH CLEARANCE
Encounter #:

UNIVERSITY OF CALIFORNIA, EDUCATION ABROAD PROGRAM:
Health Clearance Form for Students Planning to Study Abroad

Campus: UCLA
Country: Italy
Partner/Host University : UC Center Rome
Term: Winter
2023
Compliance with UC COVID-19 vaccination policy: Up to date with COVID-19 vaccines
12/9/2021

HEALTH PROVIDER: Health provider must be licensed to practice and cannot be an immediate family member (AMA Code of Ethics E-8.19). Only disclose the 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 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, the best of my knowledge, the student is:

Licensed SPECIALIST OR PSYCHOTHERAPIST
Section & signature required if student is being treated by one.

- 1.CLEARED (Check all that apply below)
- 1a. No medical or psychiatric contraindications to UCEAP participation.

Undersignature: Signed by Tanya Brown Ph.D., CAPS Training Director on 10/21/2022 3:07:51 PM

Licensed HEALTH CARE PROVIDER (MD, DO, NP, RN, or PA)
Section & signature required for all students.

- 1.CLEARED (Check all that apply below)
- 1a. No medical or psychiatric contraindications to UCEAP participation.

Electronic authorization of mental health (MH) information sharing: Student has given specific authorization in EAP submission form for the sharing of MH information between UCLA CAPS, Ashe Center, and UCLA EAP. (Paper ROI not required)

Encounter Code
Professional: NONPHYSICIAN ON-LINE SECURE MESSAGING - EAP (98969)
Diagnosis
Health Clearance Evaluation (z13.9)

There are 2 options for submitting your Health Clearance to the UCEAP Systemwide Office:

1. eFax: (805)-893-3021 This is a secure, HIPAA-compliant eFax portal.
2. Email: healthclearance@uceap.universityofcalifornia.edu
IMPORTANT NOTE: Using non-encrypted email to send your completed health clearance is not private or secure. Also, there is a possibility that the email could be intercepted and read by others whom you did not intend to receive it.

Notify UCEAP if you have a change in your health status after submitting your initial Health Clearance. You may be required to get a second Health Clearance from your treating clinician.

Signed by Jessica Ware on 10/21/2022 3:31:54 PM

[redacted] [redacted] Acct #: [redacted] DOB: [redacted] Age: [redacted] Sex: [redacted]
1/3/2023 10:05 AM with ROGERS, KRISTEN NP for EAP CLEARANCE
Encounter #: [redacted]

Sample UCSB Health Clearance

UNIVERSITY OF CALIFORNIA, EDUCATION ABROAD PROGRAM:
Health Clearance Form for Students Planning to Study Abroad

Student Name: [redacted]			**UC Campus: UCSB**
EAP Program Name: Art, Food, and Society		Country: Italy	Host University : UC Center Term: winter

Licensed SPECIALIST or PSYCHOTHERAPIST Section & signature only required if student is being treated by one			**Licensed GENERAL PRACTITIONER (MD, DO, NP, RN, or PA)** Section & signature required for **all students.**
	1. CLEARED (Check all that apply below)	X	1. CLEARED (Check all that apply below)
	1.a No medical or psychiatric contraindications to UCEAP participation	X	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.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.)	X	1.c Student strongly advised to continue treatment abroad (e.g., counseling, medical monitoring, etc.)
			see attached clearance letters
	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).		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).
	2. NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.		2. NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.
Licensed Specialist: PRINT LEGIBLY name and credentials			**Licensed Specialist: PRINT LEGIBLY name and credentials**
			Provider Name: **ROGERS, KRISTEN NP**
			805-893-3087 UCSB Student Health 522 University Road Santa Barbara, CA 93106

Encounter Code
ON-LINE ASSESSMENT CLEARANCE 98970

Diagnosis
Medical certificate issuance (Z02.79)

Signed by Kristen Rogers, NP on 1/3/2023 10:06:03 AM

Sample UCSC Health Clearance

UCSC Global Learning Health Clearance Form

UC SANTA CRUZ | Global Learning Division of Global Engagement

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Section 1: Student Details

First and Last Name: **Email Address:** **Student ID #:** **UC Campus:**

Select your program type: UCEAP ☐ UCSC Partner Program ☐ UCSC Global Seminar ☐ UCSC Global Internship ☐

Program Title: **Program Country:** **Program Term (eg. Fall 2023):**

Are you doing two programs back to back? If so, share the name, term & location of your second program:

Are you compliant with the UC COVID-19 Policy Vaccine Mandate by either being fully vaccinated as defined by your UC campus, OR receiving a UC Approved Exception or Deferral: Yes ☐ No ☐

Section 2: Health Care Providers

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 necessary and relevant information to the UCSC/UCEAP health clearance process.

I have reviewed the student's self-reported health history and available medical records. Based on the information provided to me by the student, a review of their available medical records, specialist recommendations provided (if applicable), and knowledge of the student's UCEAP or UCSC Global Learning program destination, to the best of my knowledge, the student is:

Licensed Specialist or Psychotherapist

Section and signature <u>only required if a student is being treated by one.</u>

☐ 1. **Cleared (check all that apply)**

- ☐ 1a. No medical or psychiatric contraindications to UCEAP or UCSC Global Learning 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)
  - ☐ Student has a treatment plan
  - ☐ Student 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).
- ☐ 1.e Additional details attached in a separate letter regarding student's condition.

☐ **2. Not Cleared:** There are medical or psychiatric contraindications to UCEAP or UCSC Global Learning participation.

Licensed Specialist (Name and Credentials):

Date: **Phone Number:**

Signature:

Licensed General Practitioner

Section and signature <u>is required for all students</u>. (MD, DO, NP, RN or PA).

☐ 1. **Cleared (check all that apply)**

- ☐ 1a. No medical or psychiatric contraindications to UCEAP or UCSC Global Learning 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)
  - ☐ Student has a treatment plan
  - ☐ Student 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).
- ☐ 1.e Additional details attached in a separate letter regarding student's condition.

☐ **2. Not Cleared:** There are medical or psychiatric contraindications to UCEAP or UCSC Global Learning participation.

Licensed Specialist (Name and Credentials):

Date: **Phone Number:**

Signature:

Clearing practitioner stamp or business card here :

Section 3: How to Submit

UCEAP : Submit the completed form either by email by the deadline outlined in the UCEAP Portal : healthclearance@uceap.universityofcalifornia.edu

UCSC Global Learning : Upload the completed form to the Health Clearance Pre-Departure Module in the Global Learning Portal.

NOTE: Using non-encrypted email to send your completed health clearance is not private or secure. Also, there is a possibility that the email could be intercepted and read by others whom you did not intend to receive it.

UCEAP
UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Appendix

Sample Country-Specific Forms

2023 Annual Health Update

UNIVERSITY OF THE WEST INDIES
CAVE HILL CAMPUS

MEDICAL CERTIFICATE TO BE COMPLETED PRIOR TO ACCEPTANCE FOR ADMISSION TO THE UNIVERSITY OF THE WEST INDIES

PLEASE READ THE FOLLOWING GUIDELINES CAREFULLY BEFORE COMPLETING THE FORM

1. **Part A** is to be completed and signed by the applicant in the presence of the examining doctor
2. **Part B** is to be completed by a registered Medical Practitioner who has examined the applicant
3. All applicants must provide evidence of "up to date" vaccination against **Measles, Mumps, Rubella, Tetanus and Polio** (see Part B –No 2 on the Immunization Record). In cases where immunization is medically contraindicated, the candidate must provide a **signed statement** from a physician giving reasons for such contraindications.
4. Candidates registering for the MB BS Undergraduate Medical programme are required to show additional evidence of immunization against **Hepatitis B** and **Varicella** by the end of year 2.
5. Persons from **Malaria endemic countries** are required to report to **the Medical Officer on campus** within 14 days of arrival in Barbados.

PART A (Print in BLOCK letters)

Name: _____ _____ _____
(Surname) *(First Name)* *(Middle Name)*

Faculty: _____ UWI Registration No: _____

Address: _____

Telephone number: _____ Date of birth: _____ Sex: M ❑ F ❑
dd/mm/yyyy)

Name of Parent/Guardian/Next of Kin _____ Telephone No: _____

Have you been a student of UWI previously? Yes ❑ No❑

If yes, indicate campus Mona ❑ Cave Hill ❑ St. Augustine ❑ and year of entry _____

(Please check ✓ the column which applies)

	No	Yes	Provide details if you answered yes to any of the following
Do you suffer from any chronic disease or physical disability?			
Have you or any member of your household suffered from tuberculosis?			
Have you ever had a mental disorder?			
Do you have any known allergies?			
Are you currently taking any regular medication?			
Have you had a surgical procedure			

Signature: _____ Date: _____
(dd/mm/yyyy)

PART B (To be completed by a registered medical practitioner)

Students in the MB BS Programme should ensure that Section 2 is also completed by their examining doctor.

PHYSICAL EXAMINATION

Height (m) _____Weight (kg) _____

Urinalysis: Albumin ❑ Glucose ❑ Other ❑ (please state) _____

Pulse: _____ BP: _____ Vision (without glasses): _____ (with glasses)_____

(In the following table please check ✓ the column which applies)

	No	Yes	If yes, provide details below
Is there any abnormality on general physical examination?			
Is there any physical or mental disability which might handicap the student in his/her studies?			
Is there any evidence of recent infectious disease?			
Is there any history of allergy to drugs or other substances?			
Has the candidate been treated for/ is being treated for any of the following conditions? Epilepsy ❑ Hypertension ❑ Mental Illness ❑ Diabetes ❑ Asthma ❑			

Please indicate any other conditions which may be considered significant.

IMMUNIZATION RECORD (A COPY of the original immunization record should be appended to this document)

SECTION 1 (all students)

VACCINE	DATE (dd/mm/yyyy)
MMR (1st dose)	
MMR (2nd dose)	
Boosters (T/Td/Tdap)	
Boosters (T/Td/Tdap)	
Polio	

SECTION 2 (students in the MB BS Programme)

VACCINE	DATE (dd/mm/yyyy)
Hepatitis B 1st dose	
Hepatitis B 2nd dose	
Hepatitis B 3rd dose	
Varicella (Chicken Pox) 1st dose	
Varicella (Chicken Pox) 2nd dose	

NB: Where proof of immunization is unavailable, clinical or laboratory evidence of immunity must be provided

Physician's Name: _____ **Signature:** _____

Address: _____

_____ **Date:** _____

Physician's Stamp

N.B. If necessary for information requested, details may be submitted on a separate sheet of paper.

MEDICAL CERTIFICATE

[Annex to the law of 15/12/1980 on entry to the territory, stay, settlement and removal of foreigners]

I, the undersigned medical doctor (name and surname), certify that I have examined today:

Mr./Mrs./Ms. (name and surname)
Nationality
Date and place of birth
Residence

and have found that he/she is not suffering from any of the following diseases that may endanger public health:

1) quarantine diseases as referred to in the International Health Regulations of the World Health Organization, signed in Geneva on May 23, 2005;
2) tuberculosis of the respiratory system that is active or has a progressive tendency;
3) other infectious or contagious parasitic diseases, provided that they are the subject, in Belgium, of protective measures for Belgian nationals.

Issued at …… on ……

Doctor's signature

Stamp of doctor

If applicable, stamp of the Belgian diplomatic or consular post (Seal)

at ……., on

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

MALARIA PROPHYLAXIS
PARTICIPATION AGREEMENT

I (*Print Student Name*)_____
understand that malaria is present in various parts of Botswana year-round, including in urban areas, though not in Gaborone. I understand that travelers to sub-Saharan Africa have the greatest risk of both getting malaria and dying from their infection. I understand that transmission is generally higher in Africa south of the Sahara than in most other areas of the world.

I understand that most residents of the United States have never developed resistance (immunity) to the disease and that malaria infection in a non-immune person can quickly result in a severe and life-threatening illness.

I agree to consult with my UC campus Student Health Services physician before my participation in the Education Abroad Program in Botswana regarding the anti-malaria prophylaxis treatment most appropriate and learn about personal protective measures.

I agree to continue the prescribed malaria prophylaxis regime if I plan to leave the urban Gaborone area and that missed or delayed doses may increase the risk of getting malaria.

I understand that anti-malarials are not 100% effective so insect protection measures are essential in addition to any prophylactic regimen. I agree that I will follow personal protection measures (i.e. wear appropriate clothing, use permethrin-treated bed nets, use of aerosol insecticides, vaporizing mats and mosquito coils, etc.)

As a voluntary participant in the Education Abroad Program in Botswana, I will follow the doctor's recommended malaria prophylaxis as prescribed and I certify that I have read and understood the above. I understand that failure to comply with these requirements could result in my dismissal from the program.

Signature of Student _____

_____ _____
UC Campus Date

Sample Chinese health form for students that will be studying in China for more than six months (ex. PKU Year, PKU Spring+Summer Internship) and plan to apply for a residence permit after arrival.

China *(more than six months)*

格 检 查 记 录

PHYSICAL EXAMINATION RECORD FOR FOREIGNER

Must match passport.

姓名 Name — Last, First

Sex ❑ 女 Female — 出生日期 Date of birth — YYYY-MM-DD — Y M D 日

Photo officially stamped by clinic, hospital, or physician.

现在通讯地址 Present mailing address

血型 Blood Type

国籍 Nationality — Citizenship. Must match passport.

出生地址 Place of birth — State and country

photo

过去是否患有下列疾病：（每项后面请回答“否”或“是”）
Have you ever had any of the following diseases? (Each item must be answered “ Yes ” or “ No ”)

斑疹伤寒	Typhus fever	❑ No	❑ Yes	菌痢	Bacillary dysentery	❑ No	❑ Yes
小儿麻痹症	Poliomyelitis	❑ No	❑ Yes	布氏杆菌病	Brucellosis	❑ No	❑ Yes
白喉	Diphtheria	❑ No	❑ Yes	病毒性肝炎	Viral hepatitis	❑ No	❑ Yes
猩红热	Scarlet fever	❑ No	❑ Yes	产褥期链球菌感染	Puerperal streptococcus infection	❑ No	❑ Yes
回归热	Relapsing fever	❑ No	❑ Yes				
伤寒和付伤寒	Typhoid and paratyphoid fever	❑ No	❑ Yes	流行性脑脊髓膜炎	Epidemic cerebrospinal meningitis	❑ No	❑ Yes

过去是否患有下列危及公共秩序和安全的病症：（每项后面请回答“否”或“是”）
Do you have any of the following diseases or disorders endangering the Public order and security?
(Each item must be answered “ Yes ” or “ No ”)

毒物瘾	Toxicomania			❑ No	❑ Yes
精神错乱	Mental confusion			❑ No	❑ Yes
精神病	Psychosis:	躁狂型	Manic psychosis	❑ No	❑ Yes
		妄想型	Paranoid psychosis	❑ No	❑ Yes
		幻觉型	Hallucinatory psychosis	❑ No	❑ Yes

The remainder of the form must be completed in full by the physician. Please note metric measurement units.

Height cm	Weight kg	Blood pressure mmHg
发育情况 Development	营养情况 Nourishment	颈部 Neck
视力 Vision 左 L 右 R	矫正视力 Corrected vision 左 L 右 R	眼 Eyes
辨色力 Colour sense	皮肤 Skin	淋巴结 Lymph nodes
耳 Ears	鼻 Nose	扁桃体 Tonsils
心 Heart	肺 Lungs	腹部 Abdomen

脊 柱 Spine	四 肢 Extremities	神 经 系 统 Nervous system

其 它 所 见
Other abnormal findings

Physician must indicate something in each box, even if it is "none found."

胸部 X 线检查 Chest X – ray exam.	Attach original X-ray report, not films. Photocopies are not accepted.	心电图 ECG	Attach original printout.

化验室检查 （包括艾滋病、梅毒血清学诊断） Laboratory exam. (HIV, Syphilis serodiagnosis)	Must state clearly: AIDS – negative or positive Syphilis – negative or positive The original HIV test must be attached, photocopies are not accepted.

未 发 现 患 有 下 列 检 疫 传 染 病 和 危 害 公 共 健 康 的 疾 病 ：
None of the following diseases or disorders found during the present examination:

If none found, physician should write "none found."

- ❑ 霍 乱 Cholera
- ❑ 黄热病 Yellow fever
- ❑ 鼠 疫 Plague
- ❑ 麻 疯 Leprosy
- ❑ 性 病 Venereal disease
- ❑ 开放性肺结核 Opening lung tuberculosis
- ❑ 艾 滋 病 AIDS
- ❑ 精 神 病 Psychosis

意 见
Suggestion

If any.

检查单位盖章
Official stamp

Official stamp of clinic, hospital, or physician. An address stamp is acceptable.

Physician that completed the exam signs and dates the form.

医 师 签 字
Signature of physician

日期
Date

YYYY-MM-DD

UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

MALARIA PROPHYLAXIS
PARTICIPATION AGREEMENT

I (*Print Student Name*)_____
understand that malaria is present throughout Ghana year-round, including in urban areas. I understand that travelers to sub-Saharan Africa have the greatest risk of both getting malaria and dying from their infection. I understand that transmission is generally higher in Africa south of the Sahara than in most other areas of the world.

I understand that most residents of the United States have never developed resistance (immunity) to the disease and that malaria infection in a non-immune person can quickly result in a severe and life-threatening illness.

I agree to consult with my UC campus Student Health Services physician before my participation in the Education Abroad Program in Ghana regarding the anti-malaria prophylaxis treatment most appropriate and learn about personal protective measures.

I agree to continue the prescribed malaria prophylaxis regime through my stay in Ghana and that missed or delayed doses may increase the risk of getting malaria.

I understand that such malaria prophylaxis is required by the regulations of the University of Ghana.

I understand that anti-malarials are not 100% effective so insect protection measures are essential in addition to any prophylactic regimen. I agree that I will follow personal protection measures (i.e. wear appropriate clothing, use permethrin-treated bed nets, use of aerosol insecticides, vaporizing mats and mosquito coils, etc.)

As a voluntary participant in the Education Abroad Program at the University of Ghana, I will follow the doctor's recommended malaria prophylaxis as prescribed and I certify that I have read and understood the above. I understand that failure to comply with these requirements could result in my dismissal from the program.

Signature of Student _____

_____ _____
UC Campus Date

THE HEBREW UNIVERSITY OF JERUSALEM
ROTHBERG INTERNATIONAL SCHOOL
Office of Academic Affairs

Report of Medical Examination

Please keep in mind that we do not accept forms completed by a relative.
Incomplete forms will not be accepted.

The applicant should complete this section.
PLEASE TYPE OR PRINT CLEARLY AND BRING A COPY OF THIS FORM WITH YOU TO JERUSALEM.

Name of Applicant_____Social Security Number ____

Please indicate the program to which you are applying _____

Address _____

E-mail Address _____

The physician should complete the remainder of this report of medical examination.

To the examining physician - Your health evaluation is an essential part of the application for participation in study abroad programs at the Hebrew University. We require a full physical examination. Please include results of your lab work on this report; do not submit lab reports with this evaluation.

Date of Birth_____Age_____Gender _____

Past or present illnesses (Please give dates, complications, and any residual symptoms):

A. History of heart disease (valve disorders, congenital malfunctions, etc.) _____

B. Rheumatic fever (heart involvement) _____

C. Diseases of the digestive tract: (peptic ulcer; biliary tract disease, chronic or recurrent diarrhea, severe constipation, vomiting spells, hernia, appendicitis) _____

D. Respiratory diseases (tuberculosis, asthma, chronic bronchitis, bronchiectasis, sinus disease) _____

_____

E. Urinary tract diseases (nephritis, nephrosis, calculi, recurrent bladder or prostatic disease, history of urinary tract infection)_____

F. Disorders of menstruation (give details) _____

G. Diabetes mellitus _____

H. Hypertension _____

I. Migraine or severe headaches (dizzy spells, strokes) _____

J. Epilepsy, fainting spells, history of head injuries _____

K. Muscle disease _____

L. Allergic diseases (hay fever, food allergies). Please record causative factors_____

M. Chronic skin diseases _____

N. Severe injuries _____

O. Surgeries (list surgeries and dates. If none, write "none") _____

P. Systemic disease (juvenile rheumatoid arthritis, lupus, erythematosis) _____

THE HEBREW UNIVERSITY OF JERUSALEM
ROTHBERG INTERNATIONAL SCHOOL
Office of Academic Affairs

Report of Medical Examination, continued

Name of Applicant_____Social Security Number _____

Please conduct a complete examination: Height _____Weight _____

	Normal	Deviation from Normal
Skin		
Eyes		
Ears		
Hearing		
Nose		
Teeth		
Heart		

	Normal	Deviation from Normal
Lungs		
Abdomen		
Tonsils		
Feet		
Spine		
Blood pressure		
Urinalysis (dipstick & microscopic, if indicated)		

1. List special dietary requirements (i.e., low sodium) _____

2. If the applicant is receiving any medication, please attach statement of such medication with dosage and instructions to keep on file.

3. Bearing in mind the various conditions imposed by a foreign study program (lengthy absence from home, adjustment to a foreign culture, different living conditions, etc.), is the applicant emotionally stable for study abroad?

❒ Yes ❒ No, please describe: _____

_____

4. To your knowledge, has the applicant been treated by a psychologist or psychiatrist? In such cases, a supporting letter from the treating psychologist or psychiatrist may be requested.

❒ No ❒ Yes, please describe:_____

5. Restrictions on physical activity, including exercise in a fitness facility:

❒ None ❒ As follows: _____

I have examined the above-named applicant and consider him/her physically qualified to participate in study at the Hebrew University.

Name of Physician (please type or print) _____

_____ Address _____

_____ Signature of Physician

_____ Telephone _____

License No._____ Date _____

Please return the completed form to:

Office of Academic Affairs • One Battery Plaza, 25th Floor • New York NY, 10004
Tel: 1 800-404-8622 or 1 212-607-8520 • Fax: 1 212-809-4183 • E-mail: hebrewu@hebrewu.com

TECHNION INTERNATIONAL
Israel Institute of Technology

Israel -Technion
FYI Only - Does not require a physician signature

Student Health Declaration

All fields marked with an asterisk (*) are required

I the undersigned:

*Full Name: _____ *Citizenship: _____

*Social Security Number or SIN Number: _____

*Permanent Address: _____

*1. ☐ My health condition is normal and I do not have any illness
☐ I have the following illness (please specify)*
_____
_____

*2. ☐ I am currently not receiving medical care
☐ I am currently receiving medical care (please specify)*
_____
_____

*3. ☐ I have never received any mental health treatment
☐ I have received mental health treatment (please specify)*
_____
_____

*4. ☐ I have never had drug or alcohol-related problems
☐ I have had drug or alcohol-related problems (current/past)*
_____
_____

*5. ☐ I have never been hospitalized for medical reasons
☐ I have been hospitalized for medical reasons *
In (hospital):
_____
For the following reason(s):
_____

*6. ☐ I do not have learning disabilities
☐ I have learning disabilities that require me to receive special study conditions and considerations during the course of study and/or during exams.
I have the following learning disabilities*:
_____
_____

I hereby declare and confirm the above information is accurate.

*Day _____ *Month _____ *Year_____ Signature _____

* Please provide copies of all diagnostic tests, medical reports and discharge summaries from hospitalization in this regard.

**I am aware that if found eligible to be accepted into the program, I will be required to sign a "Permission to Access Personal Medical Records" form.

Please submit the complete application and additional documentation by May 30, 2015

【片面印刷　Please print this page single-sided】

Japan - Doshisha University

健康診断書 Health Certificate

(診断医に記入してもらってください/ This form should be completed by the examining physician)

日本語または英語により明瞭に記載すること。Please fill out in Japanese or English (PRINT/BLOCK) with clarity.

氏名
Name: _____ □ 男 Male □ 女 Female　生年月日 Date of birth: _____ year / month / date

1．身体検査　Physical examination

(1) 身　長 Height _____ cm　体　重 Weight _____ kg

(2) 血　圧
Blood pressure _____ mm/Hg～ _____ mm/Hg

(3) 視　力
Eyesight: (R)_____(L)_____ 裸眼 Without glasses　(R)_____(L)_____ 矯正 With glasses or contact lenses

(4) 聴　力 Hearing: □正常 normal □低下 impaired　言　語 Speech: □正常 normal □異常 impaired

2．申請者の胸部について，聴診とX線検査の結果を記入してください。X線検査の日付も記入すること（6ヶ月以上前の検査は無効。）
Please describe the results of physical and X-ray examinations of the applicant's chest x-rays (X-rays taken more than 6 months prior to this certification are NOT valid).

肺 Lungs: □正常 normal □異常 impaired　心臓 Cardiomegaly: □正常 normal □異常 impaired

← Date _____

Film No. _____

異常がある場合 in case "impaired"
心電図 Electrocardiograph: □正常 normal □異常 impaired

3．現在治療中の病気　Under medical treatment at present
□Yes (Conditions/particulars: _____) □No

4．既往症　Past history: Please indicate with ＋ or － and fill in the date of recovery
Tuberculosis.....□ (　.　.　)　Malaria.....□ (　.　.　)　Other communicable disease.....□ (　.　.　)
Epilepsy.....□ (　.　.　)　Kidney disease.....□ (　.　.　)　Heart disease.....□ (　.　.　)
Diabetes.....□ (　.　.　)　Drug allergy.....□ (　.　.　)　Psychosis.....□ (　.　.　)
Functional disorder in extremities.....□ (　.　.　)

5．志願者の既往歴，診察・検査の結果から判断して，現在の健康状態は充分に留学に耐えうるものと思われますか？
Yes又はNoにチェックをしてください。
In view of the applicant's history and the above findings, do you think his/her health status is adequate to pursue studies in Japan?

Yes ☐　No ☐

6．特記すべき事項はありますか？Yes又はNoにチェックをしてください。Yesの場合は、詳細を記載してください。
Do you have any particulars or additional comments? Please check Yes or No. If you answered "Yes", please fill in the details.
Japan?

Yes ☐　No ☐

_____

_____

_____

_____

日付 Date: _____　署名 Signature: _____

医　師　氏　名 Physician's name (Block/Print): _____

検査施設名 Office/Institution: _____

所在地 Address of Office/Institution: _____

受験番号Application No. _____

国際基督教大学 International Christian University

健康診断問診票 Health Exam Report

この問診票は皆さんの在学中の健康管理（健康診断・健康相談）に役立てるものです。記入内容については秘密を守り、皆さんの健康管理以外には使用致しません。入学日前6ヶ月以内に医師の診断を受けてください。日本国内では、母国と全く同様の治療・検査・薬の処方などが受けられない場合があります。常用薬のある方は、滞在期間中の薬を必ずご持参下さい。また、滞在中治療、検査や処方が必要と思われる場合は、英文の医師の診断書をご持参下さい。健康診断、健康相談の際に必要なため、2択の性別を使用しています。

This report will be used for the purpose of managing your health (health exams, health consultations) while you are enrolled at ICU. The privacy of reported information will be protected, and reported information will not be used for purposes other than that stated above. Please undergo a health exam from a physician within 6 months before the date of your matriculation. Treatments, examinations, prescriptions, etc. in Japan may differ from those in your home country. Please make sure to bring medicines you will need during your stay in Japan. Also, if you think you will need treatment, examinations, or prescriptions while in Japan, please bring a physician's report written in English. **Two choices of your sex are intended for the annual health check-ups and for health consultations.**

本人記入欄 TO BE FILLED IN BY STUDENT

氏名 男 / 女

Name: _____ _____ Male / Female

姓 Family 名 Given

生年月日 国籍

Date of birth: ____年____月____日 Nationality: _____

YYYY MM DD

医師記入欄 TO BE FILLED IN BY STUDENT'S PHYSICIAN
検査項目は、漏れなく楷書でご記入ください PLEASE FILL IN ALL EXAM ITEMS (PLEASE PRINT)

1. 身長 Height: cm	2. 体重 Weight: kg	3. BMI:

4. 視力 Vision: 正常 Normal ☐ 異常 Abnormal ☐ 異常の場合、詳細 Description of abnormalities, if any ( ) 裸眼 Uncorrected ☐ 矯正 Corrected ☐

5. 聴覚 Hearing: 正常 Normal ☐ 異常 Abnormal ☐ 異常の場合、詳細 Description of abnormalities, if any ( )

6. 検尿 Urinalysis: 蛋白 Protein ( ) 糖 Sugar ( )

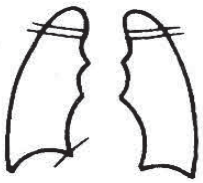
7. 血圧 Blood pressure /

8. 結核検査：以下のA**または**Bのいずれかを記載して下さい。
Tuberculosis test: Please fill in **either** A or B below.

A. 胸部エックス線検査 Chest x-ray exam

・入学前6ヶ月以内のものに限る
Must have been taken within the last 6 months before the date of your matriculation.

撮影年月日 Date of exam ____年____月____日 YYYY MM DD



所見: Diagnosis: 正常 Normal ☐ 異常 Abnormal ☐

異常の場合、詳細 Description of abnormalities, if any

B. ツベルクリン反応検査または血液検査 Skin test or blood test

・入学前6ヶ月以内のものに限る
Must have been taken within the last 6 months before the date of your matriculation.

☐ TB skin test
☐ TB blood test (T-Spot/QFT-GIT)

検査年月日 Date of test ____年____月____日 YYYY MM DD

結果: Result: 陰性 Negative ☐ 陽性* Positive* ☐

＊陽性の方は胸部エックス線検査も併せて受けて下さい。
*Individuals who tested positive: please also undergo a chest x-ray exam

※裏面もご記入下さい。OVER

受験番号Application No. _____

9.主な既往症と罹患時の年齢 （ 気管支喘息、心臓病、てんかん等）
Major past illnesses and age(s) when affected (bronchial asthma, heart disease, epilepsy, etc.)

10.現在治療中の疾患や障がい
Diseases or disorders currently undergoing treatment

11.その他・特記事項(アレルギーの有無、持参薬)
Other (allergies, medications)

12.予防接種歴　以下の病気になったこと、また予防接種を受けたことはありますか？
Immunization history: Has the person named above ever contracted or received vaccinations for the following diseases?

	罹患 Contracted?	予防接種 Vaccinations 1回目 1st	2回目 2nd	備考 Notes
MMR		/ /	/ /	
麻 疹 Measles	Yes / No	/ /	/ /	
風 疹 Rubella / German measles	Yes / No	/ /	/ /	
流行性耳下腺炎 Mumps	Yes / No	/ /	/ /	
水 痘 Varicella / chicken pox	Yes / No	/ /	/ /	

診断の結果上記のとおり相違ないことを証明する。
I certify that the physical condition of the person named above is as stated above.

医療機関名及び住所
Name and address of medical facility:

年月日 Date: _____年_____月_____日
YYYY MM DD

医師氏名(楷書)
Physician's name
(please print): _____

医師署名
Physician's signature: _____

Please print NEATLY and CLEARLY

Certificate of Health

IMPORTANT NOTE

It is important that we be made aware of any medical or emotional problems which might affect you during your stay. The provided information will be treated as confidential and **will not affect your admission into the program.** However, depending on the findings, if the student is considered not to be in adequate mental and physical health for studying abroad, we may not be able to admit the student in some cases.
*This form must be completed by a medical physician. If you do not have antibodies against infectious diseases listed below, we strongly recommend that you get vaccinated.

Name	Family ____ Given ____ Middle ____		
Date of Birth	Year ____ Month ____ Day ____	**Sex**	☐ Male ☐ Female

Examination Report・Current State of Health

Eye-sight	(L)____ (R)____ ☐ Without glasses or contact lenses ☐ With glasses or contact lenses
Hearing	☐ Normal ☐ Impaired
Chest X-ray	☐ Normal ☐ Impaired Date Year ____ Month ____ Day ____
	Describe the condition in detail.
	※ Chest X-ray can be omitted if the results were negative for TB skin test(TST) or blood test(IGRA) taken within one year.
	☐ TST ☐ IGRA(QFT/T-SPOT) Date / / (Year) (Month) (Day)
	☐ Negative ☐ Positive

Record of infectious diseases and immunization

Has the student ever had the following diseases and/or received vaccination?

Measles	☐ Yes ☐ No ☐ Vaccinated	**Rubella**	☐ Yes ☐ No ☐ Vaccinated
	Date of Recovery/Vaccination: / /		Date of Recovery/Vaccination: / /
Mumps	☐ Yes ☐ No ☐ Vaccinated	**Varicella**	☐ Yes ☐ No ☐ Vaccinated
	Date of Recovery/Vaccination: / /		Date of Recovery/Vaccination: / /

Medical conditions which might affect the student's academic performance

Has the student had any serious medical problems or chronic illnesses in the past? ☐ Yes ☐ No

If "Yes", please indicate the name of the disease and recovery date.
e.g. bronchial asthma, cardiac diseases, epilepsy, etc.

Are there any physical or mental conditions that may limit the student's ability to study? ☐ Yes ☐ No

If "Yes", please describe the conditions in detail.

Does the student have any food or drug allegies? If "Yes", please describe.

Do you consider the student to be in adequate mental and physical health to participate in the study abroad program? ☐ Yes (Adequate) ☐ No (Inadequate)

If "No", please describe the reason.

Official Stamp of Instition/Clinic

Date ____

Institution/Clinic ____

Address ____

Name of Physician ____

Signature ____

健康診断証明書
Certificate of Health

注意事項 IMPORTANT NOTE

この健康診断書は、現在の健康状況で問題なく留学生活を送れるか把握するためのものです。医師の診断を受け正確に記入してもらってください。感染症の免疫が確認できない場合にはワクチン接種を強く推奨します。健康診断書に記載された情報は事前に関連部署と共有します。
The purpose of this form is to understand the student's health conditions that may affect his/her studies before he/she comes to Japan. This form must be completed by a medical physician. If a student does not have antibodies against the infectious diseases listed below, we strongly recommend that he/she to get vaccinated. The information will remain confidential, to be shared by relevant university department in advance.

医療機関印

Official Stamp of Institution/Clinic

診断日 Date

医療機関名 Institution/Clinic

所在地 Address

医師名 Name of Physician

署名 Signature

出願者情報 Applicant's information

氏名 Name

Family Given Middle

生年月日 Date of Birth (year)/ (month) / (date) 性別 Sex ☐Male ☐Female

診断事項・健康状態 Examination Report-Current State of Health

視力 Eye-sight 左 L 右 R ☐ 裸眼 Without glasses or contact lenses
☐ 矯正 With glasses or contact lenses

聴力 Hearing ☐ 正常 Normal ☐ 異常 Impaired

胸部X線検査 Chest X-ray ☐ 正常 Normal ☐ 異常 Impaired 撮影日 Date / /

所見があれば記入してください。Describe the condition in detail (The Chest X-ray photo must be less than 6 months old)

感染症などの病歴について Record of Infectious diseases and immunization

以下の感染症にかかったこと、予防接種を受けたことがありますか。
Has the student ever had the following diseases and/or received vaccination?

麻疹 Measles ☐Yes ☐No ☐Vacciated
Vaccination: 1st / / 2nd / /

風疹 Rubella ☐Yes ☐No ☐Vacciated
Vaccination: / /

流行性耳下線炎 Mumps ☐Yes ☐No ☐Vacciated
Vaccination: / /

水痘 Varicella ☐Yes ☐No ☐Vacciated
Vaccination: / /

学業上配慮すべき健康上の問題 Medical conditions which might affect the student's academic performance

既往症や持病はありますか。Does the student have any serious past medical history or chronic illness? ☐Yes ☐No
有の場合、病名と治療完了日を記入してください。If "Yes", please indicate the name of the disease and recovery date.

心身の疾病に関する所見 Are there any physical or mental conditions that may limit the student's ability to study?
☐Yes ☐No
有の場合、具体的な症状を記入してください。If "Yes", please describe the conditons in detail.

食物・薬物アレルギーがあれば記入してください。
Does the student have any food allegies or drug allegies? If "Yes", please describe.
☐Yes ☐No
有の場合、具体的な症状を記入してください。If "Yes", please describe in detail.

現在、服用している薬があれば記入してください。Is the student currently taking any medications?
☐Yes ☐No
有の場合、具体的な症状を記入してください。If "Yes", please describe in detail.

この学生は精神的および身体的に留学に行くことに適した状態ですか。Do you consider the student to be in adequate mental and physical health for full and successful participation in the study abroad program? ☐Yes ☐No
いいえの場合、具体的な理由を述べてください。 If "No", please describe the reason.

KOREA UNIVERSITY

Global Services Center, Korea University
145 Anam-Ro, Seongbuk-Gu, Seoul 02841 Korea
Tel: +82 2 3290 5177~5178/ Fax: +82 2 921 2352

Health Certificate

All exchange/visiting students are required to complete this form and submit it within the application period. Those who do not submit the form will not be accepted to Korea University. This form must be completed by a physician/doctor only.
* Only the examination taken in August to October for spring semester and February to April for fall semester is acceptable. (Date of the examination must be within 2 months from the start of the application period)

1. Student Information

Name: _____ _____ _____ Date of Birth: _____/____/____
Family name First name Middle name YYYY/ MM/ DD

Sex: □ Male □ Female

2. Physical Information

Eyesight	□ Normal	□ Impaired (Please specify:)
Hearing	□ Normal	□ Impaired (Please specify:)
Speech	□ Normal	□ Impaired (Please specify:)

Does the applicant have any allergies? (Medication, Foods, Environmental) □ Yes □ No			
If yes, please specify. This should be completed by a physician.			
Is the applicant currently under medical treatment? □ Yes □ No			
If yes, please specify. This should be completed by a physician.			
Is the applicant currently taking any medication? □ Yes □ No			
If yes, please specify. This should be completed by a physician.			
Has the applicant ever suffered from any of the following?			
□ Tuberculosis □ Diabetes □ Heart disease	□ Hepatitis A/B/C □ Asthma □ Psychosis	□ Digestive tract disease □ Communicable disease □ Epilepsy	□ Others :
If any parts of above is marked, please specify. This should be completed by a physician.			□ No remarkable history
Is there any symptom or condition that you would like to inform us other (any extra physical/psychological/other conditions) than the mentioned above? □ Yes □ No			
If yes, please specify. This should be completed by a physician.			
In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies (within one year) in Korea? □ Yes □ No			
If no, please specify. This should be completed by a physician.			

3. Medical Physician Information (Must be filled in by a physician)

Physician's Name in Print: _____

Authorized Signature: _____

Date of Examination: _____/____/____ (YYYY/MM/DD)

Medical Office Official Stamp: _____

Immigration and Naturalisation Service
Ministry of Justice and Security

Appendix TB test referral form

In order to obtain a residence permit, you (or the person you represent) must be prepared to undergo a tuberculosis (TB) test and - if necessary - treatment. If you submit the completed declaration of intent to undergo a TB test to the IND together with your application (and also meet all other conditions), the IND will grant you a residence permit as soon as possible.

You are granted this permit under the express condition that you will actually undergo a TB test within three months after having received your residence permit. Should it become clear after the issue of a residence permit that - despite signing the declaration of intent - you failed to undergo a TB test within the period of three months, this may result in a cancellation of the permit that was granted.

In order to undergo the TB test, you must make an appointment with the Municipal Health Service. For this appointment, you must complete the referral form as much as possible (part 1) and take it with you.

Please complete the referral form before you make an appointment with the Municipal Health Service. See also www.ggd.nl for information about the Municipal Health Service. The completed form signed by the Municipal Health Service, showing that you underwent a TB test, must have been received by the IND from the Municipal Health Service within three months after having received your residence permit.

The obligation to undergo the test does not apply if you are a national of one of the countries listed in the appendix 'Exemption from the obligation to undergo a tuberculosis (TB) test'. Nor does the obligation to undergo the test apply if you have an EC residence permit for long-term residents issued by another EU country or are his/her family member and were already admitted to another EU country as a family member of the long-term resident.

1 Details of foreign national to be tested (the applicant)

The State Secretary for Justice and Security asks the director of the Municipal Health Service to test the below-mentioned person for tuberculosis (in the respiratory organs), as referred to in the Aliens Act Implementation Guidelines.

Write in block letters

> The foreign national (the applicant) completes this section (part 1)

1.1 V-number (if known)

1.2 Name (as stated in the passport)

Surname

First names

1.3 Sex

☐ Male
☐ Female

1.4 Date of birth

Day *Month* *Year*

1.5 Place of birth

1.6 Country of birth (as stated in the passport)

1.7 Nationality

1.8 Civil status

☐ unmarried
☐ married
☐ registered partnership
☐ divorced
☐ widow/widower

1.9 Home address (in the Netherlands)

Street

Number

Postcode

Town

1.10 Details passport

Number

Country

Valid from (date) *Day* *Month* *Year*

To (date) *Day* *Month* *Year*

1.11.1 Do you have a spouse or (registered) partner?

☐ No

☐ Spouse

> *Please complete the requested details below*

☐ (Registered) partner

> *Please complete the requested details below*

1.11.2 Name (as stated in the passport)

Surname

First names

1.11.3 Sex

☐ Male
☐ Female

1.12.4 Nationality

1.12.5 Home address

Street

Number

Postcode

Town

2 Statement by physician from the Municipal Health Service

The undersigned, employed by the Municipal Health Service as a physician, states that he/she has, for the State Secretary for Justice and Security, tested the foreign national referred to in this form for tuberculosis (in the respiratory organs) under the below number.

> The physician from the Municipal Health Service completes this section (part 2)

2.1 Name of Municipal Health Service

2.2 Name of physician

2.3 Test number and date

Test number

Day *Month* *Year*

2.4 Place and date

Place

Day *Month* *Year*

2.5 Signature of physician

> The Municipal Health Service sends this completed and signed statement to the Immigration and Naturalisation Service. Use the address that applies to the situation of the foreign national.

2.6 Submit form

Did the foreign national submit an application for the residence purpose of work, scientific researcher, highly skilled migrant, wealthy foreign national, work experience, seasonal labour or study?

Yes
Immigratie-en Naturalisatiedienst
Postbus 5
9560 AA Ter Apel

No
Immigratie-en Naturalisatiedienst
Postbus 17
9560 AA Ter Apel

Processing of personal data

The Immigration and Naturalisation Service (IND) processes personal data when it processes your application, notification, or request. This means that if needed the IND will request data from you yourself and other organisations or persons. The IND also uses and stores data and shares them with other organisations. When doing so, the IND strictly adheres to the stipulations of privacy legislation. For instance, the IND must treat data safely and with due care. The law also gives rights. At your request, you are allowed to see which data on you the IND processes. You can also get information on why the IND does so and to whom your data have been passed on. On www.ind.nl you can read how the IND processes your data and which rights you have. You can also read how to use your rights.

MEDICAL EXAMINATION REPORT

Singapore - year students

For New Applicants:
1. The Medical Examination may be done in Singapore by any registered General Practitioner (GP). Applicants who are in their home countries/places of residence may have their Medical Examination and HIV test done in their home countries/places of residence at any medical clinic licensed to carry out such tests. If HIV testing is done in Singapore, it may be carried out with either rapid or ELISA tests.

For Renewal Applicants:
1. The Medical Examination MUST be done in Singapore by any registered GP. HIV testing may be done with either rapid or ELISA tests.

Notes for All:
1. This Medical Examination Report is to be completed by a registered doctor and returned to the examinee. The original copy of the laboratory report for HIV and the X-ray report must be attached to this Medical Examination Report only if the medical examination and testing is carried out overseas.
2. The laboratory report for HIV and the X-ray report submitted to the Immigration & Checkpoints Authority should be within THREE MONTHS from the date of the issue of the reports.

I Personal Particulars

1. Name (as in the passport): _____
2. Sex: M / F 3. Date of Birth : _____ 4. Nationality : _____
5. Passport No. : _____ 6. FIN No. (*if applicable)* : _____
7. Address in Singapore: _____

II Medical Examination

I certify that the above-named has undergone a chest x-ray and the result of his/her chest X-ray is as indicated (with a [√]):-

	Yes	No
1. TB (Chest X-ray)* Any evidence of active TB detected?	☐	☐

[*Pregnant Women are exempted from Chest X-Ray]

I certify that I have tested the above-named and the result of his/her HIV test is indicated below (with a tick [√]).

	Positive	Negative/Non-Reactive
2. HIV :	☐	☐

Name of Examining Doctor (IN BLOCK LETTERS): _____
Signature : _____ Clinic's Stamp & Address: _____
Date: _____ Telephone Number : _____
MCR no: _____

NOTE: For persons screened overseas, the name in the laboratory report for HIV and the X-ray report must be according to the name shown in the Passport.

DECLARATION

I, _____ declare that the above is not applicable to me as
(name)
I have submitted a medical report** containing the above information to Immigration & Checkpoints Authority / Ministry of Manpower*** **(not more than two years ago)** when I was granted the _____
(pass type)
on _____ valid till _____ .
(dd/mm/yy) *(dd/mm/yy)*

_____
Signature & Date

***** Those who were previously exempted from submitting the X-ray report because of pregnancy are required to submit a X-ray report certified by a Singapore registered GP, if you are not pregnant now.***
****** Delete where necessary.***

WARNING: **IT IS AN OFFENCE UNDER THE IMMIGRATION ACT TO MAKE ANY FALSE STATEMENT, REPRESENTATION OR DECLARATION**

Version 4 (4 Oct 07)

G.P.-S. 017-0194

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HOME AFFAIRS

MEDICAL CERTIFICATE

CONDITIONS OF A RECURRENT NATURE

Although the person(s) may be generally in a good state of health at the time of the examination, it would be appreciated if the medical officer/practitioner could furnish details of any disease, condition or defect the person(s) has/have suffered and which might recur.

I hereby certify that I have examined the following person(s):

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....
7. .....
8. .....

and find him/her/them—

(a) not mentally disordered* or physically defective in any way;

(b) not suffering from leprosy, veneral disease, trachoma, or other infections or contagious condition;

(c) generally in a good state of health;

except for the following defects observed:

(Please type or print)

Name of person(s)	*Details regarding the disorder, disease or disability, the seriousness thereof and the treatment, if any, prescribed/recommended*
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Official stamp and address of medical officer/ practitioner/hospital

.....
Signature of medical officer/practitioner

.....

.....

Date .....

.....

Int. code	* "Mentally disordered" includes the following:
290–299	All psychoses.
300	Neuroses.
301	Personality disorders.
303–304	Addictions.
308	Behaviour disturbances of childhood.
310–315	All forms of mental retardation.
320–349	Epilepsy and all other forms of degeneration of the central nervous system.

BI-806

G.P.-S. 017-0044

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HOME AFFAIRS

RADIOLOGICAL REPORT

Note:

(1) A radiological report of the chest is required in respect of every prospective immigrant 12 years of age and over.

(2) The radiologist must insert the names of the prospective immigrants examined by him in the space provided for that purpose on the form. **Unused spaces must be crossed out.**

(3) **A separate report is required in respect of every applicant suffering or suspected to be suffering from tuberculosis.**

I hereby certify that I have radiologically examined the chest(s) of the following person(s) and that I could find no signs of active pulmonary tuberculosis.

Name:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

_____
Radiologist

Official stamp and address of Radiologist/Hospital:

Date: _____

_____

_____

_____

Instructions for the NTU Health Exam for Incoming Exchange / Visiting Students

In order to understand the general health condition of incoming students, and to meet the regulations of National Taiwan University, all students should receive a health exam by a qualified physician. The registration procedure is not complete if the new student does not have her/his health exam form completed.

For convenience, you may take the health exam abroad, as long as all items are completed and the examination forms include the doctor's signature and a stamp from the hospital or clinic (for certification), and is no longer than 3 months old.

You must print the "NTU Incoming Exchange / Visiting Students Health Exam Form" and the "Medical Examination Requirements for Students Applying for Short-Term Study in Taiwan（**Form C**）"as below appendixes and bring them to the hospital. The required items are included in the two forms. Most importantly, please remember to bring the completed exam form with you when registering at NTU.

※ Special instructions

1. Please inform the doctor if you are pregnant. (You are allowed to skip the CXR exam when you are pregnant.)
2. Please avoid checking your urine when menstruating.
3. Fasting at least for 8 hours is indicated for laboratory tests.
4. A physical exam by a physician and a Chest X-ray exam are mandatory items.
5. The **Form C** lists the medical examination requirements for students applying for short-term study in Taiwan. Students must provide information such as, the name of the vaccine, the date of the immunization, the name of the hospital or clinic, and the signature of the physician administering the vaccine, to the physician who fills in this form. If the student does not have measles or mumps IgG antibodies, at least one dose of MMR immunization is indicated to meet the medical examination requirements.

國立臺灣大學交換暨訪問學生健康檢查表

NTU Incoming Exchange / Visiting Students Health Exam Form

107.4

姓名 **Name**		性別 **Gender**	□男**Male** □女**Female**	相片 **Photo**
學號 **Student ID**		系所 **Department**		
居留證或護照號碼 **ARC or Passport No.**		國籍 **Nationality**		
電話 **Tel No.**		生日 **Date of Birth**	年**Y** / 月**M** / 日**D** /	

個人病史 Personal History

□食物 **Food allergies**或□藥物過敏 **Drug allergies** (名稱 **Item name**:)

※理學檢查 Physical Examination

身高 Height	**cm**	**體重 Weight**	**kg**
腰圍 Waist circumference	**cm**	**血壓 Blood Pressure**	／ **mmHg**
頭頸部 Head & Neck		**脈搏 Pulse Rate**	**/min**
胸部 Chest		**心臟 Heart**	
腹部 Abdomen		**肺部 Lungs**	
肌肉、骨、關節 Muscles/Bones/Joints		**皮膚 Skin**	
其他 Others			
口腔 Oral Cavity			

視力 Visual Acuity	**裸視 Uncorrected**	**R**		**L**	
	矯正 Corrected	**R**		**L**	
辨色力 Color Differentiation	□無異常**Normal** □異常**Abnormal**				
聽力 Hearing	**右Right**	□通過**Pass** □未通過**Fail**	**左Left**	□通過**Pass** □未通過**Fail**	
※胸部X光 Chest X-Ray Report	□無活動性肺病變 **No active lung lesion** □異常**Abnormal** _____				

實驗室檢查 Laboratory Examinations

肝功能 **ALT**: **U/L**	空腹血糖 **AC sugar**: **mg/dL**	白血球數 **WBC**: **K/μL**
肌酸酐 **Creatinine**: **mg/dL**	尿酸 **Uric acid**: **mg/dL**	血紅素 **Hb**: **g/dL**
總膽固醇 **T-cholesterol**: **mg/dL**	三酸甘油脂 **Triglycerides**: **mg/dL**	血小板數 **Platelet**: **K/μL**

尿液 **Urine** 尿蛋白 **Protein**: 尿糖 **Sugar**: 尿潛血 **Occult Blood**:

個案目前是否因疾病服用藥物或接受治療 **Is the student taking medications or treatment for any disease:**

總評及建議 **Comments and Suggestions:**

醫師簽章 **Doctor's signature**:_____ 證書字號 **License No.**:_____

檢查日期 **Date of health exam**:_____ 健康檢查醫療院所名稱 **Name of the medical institution for the health exam**:**請務必加蓋機關印章，否則視同無效。Not valid if without the institution's seal.**

本表所有檢查項目皆為必要項目（All exams listed above are mandatory items.）

國立臺灣大學-短期研修健康檢查表（丙表）
National Taiwan University-Medical Examination Requirements for Short-Term Students（Form C）

檢查日期 ____/____/____
(年)(月)(日)
Date of Examination ____/____/____
(M)(D)(Y)

基 本 資 料 (Basic data)

姓 名 Name ：_____　　性別 Sex ：□男 Male　□女 Female

身份證字號 ID No. ：_____　　護照號碼 Passport No. ：_____

出生年月日 Date of Birth ：_____ / _____ / _____　　NTU 學號 **Student ID** ：_____

檢 查 項 目 (Items required)

A. 麻疹及德國麻疹(風疹)之抗體陽性檢驗報告或預防接種證明（Proof of Positive Measles and Rubella Antibody Titers or Measles and Rubella Immunization Certificates）：

a.抗體檢查 Antibody Test

麻疹抗體 Measles antibody titer　□陽性 Positive　□陰性 Negative　□未確定（Equivocal）

德國麻疹(風疹)抗體 Rubella antibody titer　□陽性 Positive　□陰性 Negative　□未確定（Equivocal）

b.預防接種證明 Immunization Certificate (含疫苗名稱、接種日期、接種單位或醫師簽章。如檢附幼時接種紀錄，其接種年齡必須大於 1 歲。)

(The certificate must include information such as the date of immunization, and the name of the hospital or clinic administering the vaccine or the signature of the physician administering the vaccine. If the childhood immunization record is submitted, it is important to include the record of the vaccines administered only after one year of age.)

□麻疹預防接種證明 Measles Immunization Certificate

□德國麻疹(風疹)預防接種證明 Rubella Immunization Certificate

c. □經醫師評估，有接種禁忌者，暫不適宜接種。(Having contraindications, not suitable for vaccination)

B. 胸部 X 光檢查肺結核（Chest X-Ray for Tuberculosis）：

X 光發現(X-ray Findings)：_____

判定(Results)：

□合格(Passed)　□疑似肺結核(TB Suspect)　□須進一步診斷(Pending)　□不合格(Failed)

□孕婦免驗 (Maternity Exemption)

備註(Note)：

一、本表為外籍學生、大陸及港澳地區學生來臺停留研修之健康檢查項目表。本表僅供參考用，學生可分別檢具預防接種證明及胸部 X 光檢查報告。This form lists the required medical examination items for students applying for short-term study in Taiwan. This form is only used for reference. Students may submit a copy of immunization certificates and the chest X-ray report instead of completing this form.

二、根據以上對_____先生/女士/小姐之檢查結果為

□合格　□不合格　□須進一步檢查

Results：According to the above medical report of Mr./Mrs./Ms._____, he/she

□has passed the examination　□has failed the examination　□needs further examination.

負 責 醫 師 簽 章 (Chief Physician)：_____（Name & Signature）

醫___療__院__所___印__章 **(Medical institution's seal)**：_____（Name & Signature）

日 期（Date）：_____/_____/_____

醫院標誌
Hospital's Logo

健康檢查證明應檢查項目表（乙表）

（國名、醫院名稱、地址、電話、傳真機）

ITEMS REQUIRED FOR HEALTH CERTIFICATE （Type B）

（National Name, Hospital's Name, Address, Tel, FAX）

檢查日期 ____/____/____
（年）（月）（日）
____/____/____
（M）（D）（Y）
Date of Examination

基 本 資 料 （BASIC DATA)

姓 名 Name ：_____
性 別 Sex ：□男 Male □女 Female
身份證字號 ID No. ：_____
護照號碼 Passport No. ：_____
出生年月日 Date of Birth ：___ / ___ / ___
國籍 Nationality ：_____

照片
Photo

實 驗 室 檢 查(LABORATORY EXAMINATIONS)

A.HIV 抗體檢查（Serological Test for HIV Antibody）：□陽性（Positive） □陰性（Negative）
□未確定（Indeterminate）
a .篩檢（Screening Test）： □EIA □Serodia □其他（Others）_____
b .確認（Confirmatory Test）：□Western Blot □其他（Others）_____

B.胸部 X 光檢查肺結核（Chest X-Ray for Tuberculosis）：（妊娠孕婦可免接受「胸部 X 光檢查」）
□正常（Normal） □異常（Abnormal）_____**※限大片攝影（Standard Film Only）**

C.腸內寄生蟲（含痢疾阿米巴等原蟲）糞便檢查（採用離心濃縮法檢查）（Stool examination for parasites includes *Entameba histolytica* etc.）(centrifugal concentration method)：
□陽性，種名(Positive, Species)_____ □陰性（Negative）

D.梅毒血清檢查（Serological Test for Syphilis）：□陽性（Positive）□陰性（Negative）
a .□RPR b .□VDRL c .□TPHA/TPPA d .□其它（Other）

E.麻疹及德國麻疹之抗體陽性檢驗報告或預防接種證明（proof of positive measles and rubella antibody titers or measles and rubella vaccination certificates）：
a.抗體檢查（Antibody test） 麻疹抗體 measles antibody titers □陽性 Positive □陰性 Negative
德國麻疹抗體 rubella antibody titers □陽性 Positive □陰性 Negative
b.預防接種證明 Vaccination Certificates
□麻疹預防接種證明 Vaccination Certificates of Measles
□德國麻疹預防接種證明 Vaccination Certificates of Rubella
c. □經醫師評估，有接種禁忌者，暫不適宜接種。(Having contraindications, not suitable for vaccination)

漢 生 病 檢 查（EXAMINATION FOR HANSEN'S DISEASE）

漢生病視診結果(Skin Examination)□正常 Normal □異常 Abnormal（※視診異常者，須進一步採檢確認）
（※If abnormal skin lesion is found, further skin biopsy or skin smear is required）
a .病理切片(Skin Biopsy)：□陽性(多菌、少菌性【Positive - MB,PB】;診斷依據：兩者之一即為陽性【Diagnostic if either of them positive】) □陰性（Negative）
b .皮膚抹片(Skin Smear)：□陽性（Finding bacilli in affected skin smears）□陰性（Negative）
※ 皮膚病灶合併感覺喪失或神經腫大(Skin lesions combined with sensory loss or enlargement of peripheral nerves)
□有（Yes） □無（No）

備註(Note)：

一、本表供外籍人士等申請在台灣定居或居留時使用。This form is for **residence application.**

二、兒童 6 歲以下免辦理健康檢查，但須檢具預防接種證明備查(年滿 1 歲以上者，至少接種 1 劑麻疹、德國麻疹疫苗)。A child under 6 years old is not necessary to have laboratory examination, but the certificate of vaccination is necessary. Child age one and above should get at least one dose of measles and rubella vaccines.

三、妊娠孕婦及兒童 12 歲以下免接受「胸部X光檢查」。 Pregnant women and children under 12 years of age are exempted from chest X-ray examination.

四、兒童 15 歲以下免接受「HIV 抗體檢查」及「梅毒血清檢查」。 A child under 15 years old is not necessary to have Serological Test for HIV or Syphilis.

五、居住於北美洲、歐洲、紐西蘭、澳洲、日本、南韓、香港、澳門及新加坡等地區或國家之申請者，得免驗腸內寄生蟲糞便檢查。 Applicants living in Northern America, Europe, New Zealand, Australia, Japan, South Korea, Hong Kong, Macao or Singapore are not required to undergo a stool examination for parasites.

六、結論：根據以上對_____先生/女士/小姐之檢查結果為□合格　□不合格。

Result: According to the above medical report of Mr./Mrs./Ms. _____ , he/she has □passed　□failed　the examination.

負責醫檢師簽章 (Chief Medical Technologist)：_____（Name & Signature）

負責醫師簽章 (Chief Physician)：_____（Name & Signature）

醫院負責人簽章 (Superintendent)：_____（Name & Signature）

日期（Date）：_____/_____/_____　**本證明三個月內有效（Valid for Three Months）**

附錄：健康檢查證明不合格之認定原則

檢查項目	不合格之認定原則
人類免疫缺乏病毒抗體檢查	一、人類免疫缺乏病毒抗體檢驗經初步測試，連續二次呈陽性反應者，應以西方墨點法(WB)作確認試驗。 二、連續二次(採血時間需間隔三個月)西方墨點法結果皆為未確定者，視為合格。
胸部X光檢查	一、活動性肺結核(包括結核性肋膜炎)視為「不合格」。 二、非活動性肺結核視為「合格」，包括下列診斷情形：纖維化(鈣化)肺結核、纖維化(鈣化)病灶及肋膜增厚。
腸內寄生蟲糞便檢查	一、 經顯微鏡檢查結果為腸道蠕蟲蟲卵或其他原蟲類如：痢疾阿米巴原蟲（*Entamoeba histolytica*）、鞭毛原蟲類，纖毛原蟲類及孢子蟲類者為不合格。 二、 經顯微鏡檢查結果為人芽囊原蟲及阿米巴原蟲類，如：哈氏阿米巴（*Entamoeba hartmanni*）、大腸阿米巴（*Entamoeba coli*）、微小阿米巴（*Endolimax nana*）、嗜碘阿米巴（*Iodamoeba butschlii*）、雙核阿米巴（*Dientamoeba fragilis*）等，可不予治療，視為「合格」。 **三、 妊娠孕婦如為寄生蟲檢查陽性者，視為合格；請於分娩後，進行治療。**
梅毒血清檢查	一、以 RPR 或 VDRL 其中一種加上 TPHA(TPPA)之檢驗，如檢驗結果有下列情形任一者，為「不合格」: （一）活性梅毒：同時符合條件（一）及（二）、或僅符合條件（三）者。 （二）非活性梅毒：僅符合條件（二）者。 二、條件： （一）臨床症狀出現硬下疳或全身性梅毒紅疹等臨床症狀。 （二）未曾接受梅毒治療或病史不清楚者，RPR(+)或 VDRL(+)，且 TPHA (TPPA)=1：320 以上（含 320）。 （三）曾經接受梅毒治療者，VDRL 價數上升四倍。 **三、梅毒血清檢查不合格者，檢具治療證明，視為合格。**
麻疹、德國麻疹	麻疹、德國麻疹抗體陰性且未檢具麻疹、德國麻疹預防接種證明者為不合格。但經醫師評估有麻疹、德國麻疹疫苗接種禁忌者，視為合格。

Appendix: Principles in determining the health status failed

Test Item	Principles on the determination of failed items
Serological Test for HIV Antibody	1. If the preliminary testing of the serological test for HIV antibody is positive for two consecutive times, confirmation testing by WB is required. 2. When findings of two consecutive WB testing (blood specimens collected at an interval of three months) are indeterminate, this item is considered qualified.
Chest X-ray	1. Active pulmonary tuberculosis (including tuberculous pleurisy) is unqualified. 2. Non-active pulmonary tuberculosis including calcified pulmonary tuberculosis, calcified foci and enlargement of pleura, is considered qualified.
Stool Examination for Parasites	1. By microscope examination, cases are determined unqualified if intestinal helminthes eggs or other protozoa such as *Entamoeba histolytica*, flagellates, ciliates and sporozoans are detected. 2. *Blastocystis hominis* and Amoeba protozoa such as *Entamoeba hartmanni, Entaboeba coli, Endolimax nana, Iodamoeba butschlii, Dientamoeba fragilis* found through microscope examination are considered qualified and no treatment is required. 3. **Pregnant women who have positive result for parasites examination are considered qualified and please have medical treatment after delivery.**
Serological Test for Syphilis	1. After testing by either RPR or VDRL together with TPHA(TPPA), if cases meet one of the following situations are considered failing the examination. (1)Active syphilis: must fit the criterion (1) + (2) or only the criterion (3). (2)Inactive syphilis: only fit the criterion (2). 2. Criterion: (1)Clinical symptoms with genital ulcers (chancres) or syphilis rash all over the body. (2)No past diagnosis of syphilis, a reactive nontreponemal test (i.e., VDRL or RPR), and TPHA(TPPA)＝1：320↑(including 1：320) (3)A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer. 3. **Those that have failed the serological test for syphilis but have submitted a medical treatment certificate are considered passing the examination.**
Measles, Rubella	The item is considered unqualified if measles or rubella antibody is negative and no measles, rubella vaccination certificate is provided. Those who having contraindications, not suitable for vaccinations are considered qualified.

10/28/2009 修訂

Natural Reserve System
Field Studies Program
Health Form Information

USA

*** DO NOT SEND FORMS LABELED **"CONFIDENTIAL"** TO THE NATURAL RESERVE SYSTEM ***

STUDENT INSTRUCTIONS

Please read the following instructions carefully:

- The Natural Reserve System ("NRS"): California Ecology and Conservation program (the "Program") requires the following three health related forms: 1) **Health History Form**, 2) **Health Clearance Form**, and 3) **Limited Authorization Form**. **IT IS MANDATORY FOR THE STUDENT TO COMPLETE AND SUBMIT ALL THREE (3) FORMS TO THE PARTY IDENTIFIED ON THE RESPECTIVE FORM.** Failure to provide any health related Program form, both completely and accurately, may be grounds for denial of acceptance to the Program and/or dismissal.

- The Program takes place in outdoor and often remote locations, please consider how the stresses of studying and working in the outdoors may affect your physical and mental health. Preexisting conditions may be intensified by living in such an environment and there may be fewer, or inadequate, local resources immediately nearby to help you manage potential triggers. If you have a **chronic medical condition,** such as severe allergies or diabetes, please be prepared to manage your condition away from close resources for extended durations of time.

- Please disclose **all** medical history on the **Confidential Health History Form**, which is submitted to the health provider performing your health clearance. Full and accurate disclosure on the Confidential Health History Form is critical because it allows your licensed physician to consult, plan, and facilitate all necessary precautions to ensure your safety throughout the Program.

Mandatory Updates regarding Changes to Your Health

You must inform your instructor Tim Miller at tijmille@ucsc.edu of any significant changes in your physical and/or mental health (including, but not limited to, changes to prescribed medications) that occur after the **Health Clearance Form** is signed by your licensed physician. You may be required to get a second health clearance should your health change after the date of your **Health Clearance Form**. Failure to disclose changes in your health, including new illnesses, injuries, allergies, can endanger your health and may be grounds for limited participation and/or dismissal from the Program.

Prescription Medication

1. Make sure that you have a legal prescription contained within the originally labeled container, and that your prescription amount will last the duration of the Program.
2. Work closely with your doctor to design a prescription treatment plan, keeping in mind that the Program is in remote areas and additional medication may be difficult to obtain immediately. Also, if you are taking any psychotropic medications, you must be stable on your medication. Medically stable means that you must be in a state where no changes in symptoms are foreseen or expected.

Checklist (Note, specific instructions can be found on each health related form, so please refer to each form for full details.)

- ☐ **PRINT and COMPLETE** the **Confidential Health History Form**, completely and accurately.
- ☐ **REQUEST an appointment** with your licensed physician. The **Health History Form** should be completed prior to the health clearance consultation with your licensed physician.
- ☐ **PRINT and PROVIDE** both the completed copy **Confidential Health History Form** and **Limited Authorization Form**, plus a blank **Health Clearance Form**, to each and every licensed physician who performs your health clearance evaluation. **DO NOT MAIL A COPY OF THE CONFIDENTIAL HEALTH HISTORY FORM TO THE NRS.**
- ☐ After your appointment, **SCAN** the original Health Clearance Form and email it to your Program Coordinator Kelly Zilliacus at CAecology@ucop.edu by the stipulated deadline.
- ☐ **KEEP** a copy of the **Confidential Health History Form** for your own records and to take with you on the program. If there have been changes to your health since you completed the form, make sure that you provide these updates on the form.
- ☐ **INFORM** the NRS of any changes in health that occur after the health clearance process. You are required to **UPDATE** the **Health History Form** for any significant changes in your health after the original clearance and will need to seek a new health clearance.

***** Failure to provide any health related Program form, both completely and accurately, may be grounds for denial of acceptance to the Program and/or dismissal.

CONFIDENTIAL

Natural Reserve System
Health History Form and Instructions

USA (*continued*)

Please complete the following **Confidential Health History Form**, completely and accurately, before the **Health Clearance Form** and requisite consultation. The **Health Clearance Form** must be completed **60 days** before the Program starts. It is a non-waivable requirement. *If you are not in compliance, you may not be approved to participate in, or may be dismissed from the Program.* Your answers on this **Confidential Health History Form** and a review of your medical and mental health records will be used during the health clearance process.

You must inform NRS of any recent medical or special needs or changes in health that occur after submitting your **Health Clearance Form**.

Complete this form BEFORE your medical appointment. Failure to provide complete and accurate information may be grounds for non-participation and/or dismissal in the Program. Your confidential disclosure could prevent complications during an emergency and/or help to plan better for a successful and safe experience in the Program.

STUDENT INFORMATION:

Last name _____ First _____ Middle _____ Sex: M ☐ F ☐

Person to notify in case of emergency: _____
NAME

_____ _____ _____ _____
ADDRESS: STREET CITY STATE, ZIP CODE DAYTIME PHONE, INCLUDE AREA CODE

GENERAL HEALTH:

List any recent or continuing health problems: _____

List any physical or learning disabilities: _____

Are you currently (last 12 months) under the care of a doctor or other health care professional, including mental health treatment? Yes ☐ No ☐

Doctor's Name: _____ Phone/Fax: _____

Address: _____

For what condition(s): _____

SURGERIES: List type and year _____

_____

DRUG/FOOD ALLERGIES: List any drug or food allergies and briefly describe reaction: _____

_____

MEDICAL HISTORY: Students with known and ongoing medical conditions must prepare for and manage their condition during the program.

	Y	N	Date		Y	N	Date		Y	N	Date
Chronic headaches/migraines				Ulcer/colitis				Back/joint problems			
Epilepsy/seizures				Hepatitis/gallbladder				High blood pressure			
Asthma/lung disease				Bladder/kidney problems				Thyroid problems			
Heart disease				Diabetes				Recurrent or chronic infectious diseases			
Anemia or bleeding disorder				Cancer/tumors				Other (List) _____			

MENTAL HEALTH HISTORY: Have you ever been diagnosed, been treated for, or hospitalized for the following?

	Y	N	Please provide an explanation below for any box you have checked
Any mental health condition, including depression/anxiety			
Substance abuse (alcohol or drugs)			
Eating disorder (anorexia/bulimia)			
Are you taking/have ever taken medication for above?			

IMMUNIZATION RECORD (Indicate most recent date):

	Date		Date		Date
Polio immunization		Measles		Mumps	
Tetanus booster or Tetanus/diphtheria booster		Rubella		MMR	

MEDICATIONS: Student is responsible for ensuring that all medications are legally permissible.

Are you currently taking any medications? **Y** ☐ **N** ☐ Specify name, type & brand of any medication and whether you use inhaler, bee sting kit.

_____

*SERVICES YOU WILL NEED TO FACILITATE YOUR EDUCATION (e.g., note takers)

*You must register with your campus DSP office to pursue accommodations in the NRS program.

_____

I certify that all responses made on this form are complete, true and accurate. I understand that if there are any changes in my health status, I will contact NRS immediately. I understand that if I withhold information on this form I may be withdrawn from the program.

Student's Signature: _____ Date: _____

Natural Reserve System
Health Clearance Form Instructions

IMPORTANT PROGRAM INFORMATION

- The Natural Reserve System ("NRS"): California Ecology and Conservation program (the "Program) exposes students to a wide range of state ecosystems as they travel from one reserve in the UC Natural Reserve System to another.
- Students spend 7 weeks at Natural Reserves in California. Environments include mountains, desert, coastal, and island. The Program includes strenuous outdoor activities (e.g., camping and hiking)
- Research projects involve forests, fields, ocean, streams, animals or insects, and take place during the day and after dark.
- The academic and research work and study field trips in remote locations are demanding.
- Students camp, receive instruction outdoors and live in close quarters in biological field stations.
- Group dynamics are extremely important. Students must be able to manage well within a group.
- Access to medical attention: Although reliable medical services are available throughout California, students will be living in rural environments. These remote locations may be hours from medical facilities. Communication and transportation are difficult at some Natural Reserves and evacuations and medical care may be delayed.

REQUIREMENTS

- Licensed physician must be professionally licensed and cannot be an immediate family member. *AMA Code of Ethics E-8.19*
- The student's name and Program information must appear on the form. Blank forms are not acceptable.
- The student must be assessed to participate in the Program by a physician and a specialist if the student is currently being treated by one.
- NRS may not approve a student's participation in the Program unless a licensed physician certifies that the student is medically stable.
- Licensed physicians must provide legible contact information.
- 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

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.*

- □ **Do not delay** in making your health clearance appointment. If you do not comply with this requirement, you may not be approved to participate in, or may be dismissed from NRS. *Even if the Program allows a health clearance through a licensed physician, NRS reserve the right to require a clearance through the campus Student Health Center.*
- □ **Complete the *Confidential Health History Form***
- □ **Legibly write** your name, the Program term, and year on the *Health Clearance Form* before your appointment.
- □ **After your appointment, scan the original *Health Clearance Form* and email it to** your Program Coordinator Kelly Zilliacus at CAecology@ucop.edu **by the stipulated deadline.**
- □ **Inform** the NRS 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, the Program.

HEALTH CARE PROVIDER INSTRUCTIONS

- □ **The student must present to you a completed *Confidential Health History Form*.** A physical examination is not needed unless required by the UC Student Health Center.
- □ **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.
- □ **Focus on any condition requiring medication and/or continued treatment while in the field**.
  - Students may be cleared for participation if:
    a) in the opinion of the examining health care provider and/or specialist any medical condition is under control,
    b) they have a contracted treatment plan in place (if there is any evidence of recent physical/mental health treatment), for required and recommended care during the Program, considering the unique geography, rugged terrain, and remoteness of NRS site locations, and
    c) they have been stable on their medication for a reasonable period.

Natural Reserve System
Health Clearance Form

Please print clearly using blue or black ink.

Last Name of Student | *First Name of Student* | *Term and Year of NRS Program*

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 NRS'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 course involves seven weeks of continuous travel and field study in remote California natural reserves**, 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)
   - ☐ a. No medical or psychiatric contraindications to NRS participation.
   - ☐ b. Student advised to arrange services to facilitate education. A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.
   - ☐ c. Student advised to arrange services to facilitate a healthy and safe stay during the program (e.g., regularly available psychiatric therapy, etc.) **Indicate that student has treatment plan in place and is stable.**
   - ☐ d. Student advised to carry a sufficient supply of medication to last through entire program. If on medication, please list.
   - ☐ e. List significant allergies (e.g., medication, food, etc.):
2. ☐ **NOT CLEARED:** There are **medical or psychiatric** contraindications to NRS 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)
   - ☐ a. No medical or psychiatric contraindications to NRS participation.
   - ☐ b. Student advised to arrange services to facilitate education. A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.
   - ☐ c. Student advised to arrange services to facilitate a healthy and safe stay during the program (e.g., regularly available psychiatric therapy, etc.) **Indicate that student has treatment plan in place and is stable.**
   - ☐ d. Student advised to carry a sufficient supply of medication to last through entire program. If on medication, please list.
   - ☐ e. List significant allergies (e.g., medication, food, etc.):
2. ☐ **NOT CLEARED:** There are **medical or psychiatric** contraindications to NRS participation.

Licensed Physician/Health Provider: MD, DO, NP, RN, or PA (**PRINT LEGIBLY name and title)** | Phone number (include area code)

Signature: | Date:

LICENSED PHYSICIAN RUBBER STAMP OR BUSINESS CARD HERE

Upon completion, the student must scan the original Health Clearance Form and email it to your Program Coordinator Kelly Zilliacus at CAecology@ucop.edu by the deadline. **One copy:** Health care provider **Original:** Student keeps for personal record **Scan of Original:** Email to your Program Coordinator Kelly Zilliacus at CAecology@ucop.edu

Natural Reserve System
Limited Authorization Form Instructions

Please submit with your Health Clearance Form

INSTRUCTIONS:

1. COMPLETE ALL BLANK sections

2. SIGN and DATE the form

3. PROVIDE A COPY of this limited authorization to each licensed physician, health practitioner, specialist, who has seen you in the past 12 months, or your UC campus student health center in connection with the Health Clearance process

4. SCAN the ORIGINAL, SIGNED, form and EMAIL it to your Program Coordinator Kelly Zilliacus at CAecology@ucop.edu along with your Health Clearance Form by the Health Clearance deadline listed in your Pre-Departure Checklist.

See form on next page.

Natural Reserve System
Limited Authorization Form

USA (*continued*)

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

Use and Disclosure of Health Information

I, _____, ("Student") participating in the Natural Reserve System ("NRS"): California Ecology and Conservation program (the "Program"), hereby authorize all licensed physicians, all health practitioners, and all psychotherapists, who have provided care to me within the last twelve (12) months, including each person listed on the last page of this limited authorization to release to the Natural Reserve System, University of California Office of the President (UCOP), 1111 Franklin Street, 6th Floor, Oakland, CA 94607-5200

the following information:

a. ☒ All health information pertaining to my medical history, mental or physical condition and treatment received — ***OR***

☐ Only the following records or types of health information (including any dates):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):

☒ Mental health treatment information[1]

☐ HIV test results

☒ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes as defined by HIPAA (45 C.F.R. section 164.501).

Further, I authorize the NRS and its agents to contact my emergency contact as indicated on the emergency form, in connection with my general welfare abroad.

Purpose

Purpose of requested use or disclosure: ☐ patient request *OR* ☒ other: To obtain health clearance for the Student to participate in the Program; to provide information on any conditional health clearance provisions applicable to the Student participation in the Program; to inform any health care decision related to the Student that occurs during the Program; and to notify the emergency contact on record at NRS of any health emergency Student suffers during the Program.

Expiration

This Limited Authorization expires upon completion of Student's participation in the Program.

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

My Rights

I may refuse to sign this Limited Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2] However, this Limited Authorization must be signed to obtain a health clearance to participate in the Natural Reserve System: California Ecology and Conservation program.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this Limited Authorization at any time, but I must do so in writing and submit it to the following address:

Kelly Zilliacus
UC Santa Cruz
115 McAllister Way
Santa Cruz, CA 95060

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Limited Authorization.

I have a right to receive a copy of this Limited Authorization.[3]

Information disclosed pursuant to this Limited Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

A scanned copy attached to an email message, a facsimile, or a photocopy of this signed and completed Limited Authorization may be used as if it is a signed and completed original.

Signature

Date: _____ Time: _____ am/pm

Signature: _____

(patient/representative/spouse/financially responsible party)

[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(d)(1), (e)(2)).

LIST OF HEALTH PROVIDERS

List each licensed physician, including, but not limited to, each physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who has provided care to Student within the last twelve (12) months:

Please print.

☒ UC Student Health Service

☒ UC Student Counseling Center

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

2023 Annual Health Update

UCEAP™
UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

International Health, Safety & Crisis Management
UC Education Abroad Program
Front Desk Tel: 805.893.4762
Email: IHSCM@uceap.universityofcalifornia.edu