GONZAGA UNIVERSITY

# STUDY ABROAD HEALTH CLEARANCE INSTRUCTIONS

## For Students

1. Fill out the student sections on pages 1 and 2. Take all the pages with you to your physical exam appointment.

2. During your physical exam, be sure your provider's office completes pages 3, 4, and 5, including a review of the vaccinations recommended by the Centers for Disease Control for your travel destination(s).

3. You must ensure that the completed and fully signed **Study Abroad Health Form (5 pages)** is emailed, faxed or dropped off at or mailed to Gonzaga Study Abroad office. (Email: studyabroad@gonzaga.edu; Fax: 509-313-5987; Mailing: 502 E. Boone Ave AD 85, Spokane, WA 99258-0085; Office Location: Hemmingson Center Rm 102.) The health form may be completed up to *five months prior to departure*, and must be received by the deadline given to you by your program advisor.

4. This form is required by GU and is in addition to any forms required by your program. This requirement cannot be waived and is a condition of full acceptance into the program.

5. Some programs will require a separate health clearance form due to program requirements and/or country-specific risks. Be sure to get any additional/program-specific forms completed before the physical.

## For Medical Providers

**Students who wish to study abroad must be medically cleared by a healthcare provider (MD, DO, ARNP, or PA only). Please include the following steps and considerations when conducting this assessment:**

1. Discuss/review the student's health history from page 1, paying particular attention to medications the student may need, allergies, and all currently active health problems. Students may be cleared for participation with these conditions provided they are in compliance with recommended care plans and stable on their medication.

2. Review the Centers for Disease Control vaccine recommendations for their travel destination(s) and determine what, if any immunizations the student may need and assist the student in getting these completed (administer, prescribe, refer, etc.). While the medical provider may recommend travel immunizations, it is the student's responsibility to obtain the necessary immunizations for study abroad.

3. Perform a thorough physical examination. Please document on page 4.

4. Please impress on the student that they need to take a sufficient amount of medication to last for the duration of the program abroad, or verify that the medication is locally available and legal.

5. Assess the need for any continued health care, counseling or laboratory testing while abroad so the student can determine the availability of adequate facilities at the program site.

6. Determine the student's level of health and fitness of undertaking participation on a study abroad program and initial health clearance status where indicated on page 5.

**Students may be medically cleared for participation as long as, in the opinion of the examining provider, any condition the student may have is under control and has been stable for a reasonable period.**
**Final clearance will be completed by the Gonzaga University Study Abroad Office.**

For Office Use Only: Date: _____ Received by: _____
Program: _____ Term: _____ Scanned: ☐ Uploaded: ☐

# STUDY ABROAD HEALTH CLEARANCE FORM

## MEDICAL SELF-DISCLOSURE: COMPLETED BY STUDENT

| Last Name: | First Name and Middle Initial | DOB (MM-DD-YY): |
|---|---|---|
| Zag ID#: | Gender: ☐ F ☐ M ☐ Other:_____ | Phone: ( ) |
| Person(s) to be notified in case of emergency: Name: _____ Relationship: _____ Email: _____ | | Phone Hm (_____)_____ Cell (_____)_____ |

Medications (including non-prescription) presently taking:

_____

_____

Do you have allergies (drug, food, environmental, or other)? ☐ YES ☐ NO If yes, please explain:

_____

_____

Do you have any dietary restrictions? ☐ YES ☐ NO If yes, please explain:

_____

_____

MEDICAL OR HEALTH CONCERNS – Please CHECK/MARK conditions/diseases you have or had. If NONE apply, check this box ☐

| YES | Condition | YES | Condition | YES | Condition |
|---|---|---|---|---|---|
| | ADD/ADHD/ Learning Disability | | Eating Disorder | | Migraine/Frequent/Severe Headaches |
| | Alcohol or Substance Abuse | | Eczema/Psoriasis/Skin Disorder | | Mobility Limitations |
| | Anemia or Other Blood Condition | | Epilepsy/Seizures | | Mononucleosis |
| | Arthritis | | Gastrointestinal Disorder/Ulcers | | Neurologic Condition |
| | Asthma/Lung Disease/ Pneumonia | | Head Injury/Concussion/Loss of Consciousness | | Spinal Problems/Injury |
| | Bladder/Kidney Disease | | Hearing Loss | | Stroke |
| | Cancer | | Heart Disease/High Blood Pressure | | Thyroid Problem |
| | Depression/Anxiety/Psychological Disorders | | Hepatitis | | Vertigo/Dizziness/Fainting |
| | Diabetes | | Immunocompromising Condition/HIV | | Vision Impairment/Eye issues |
| | Ear/Nose/Throat Problems | | Menstrual/Gynecologic Problems | | Other: |

Surgery (specify):

Chronic or long term on-going condition:

List date(s) and reason(s) for any hospitalizations:

Have you had severe symptoms and/or treatment for emotional or psychological problems? Describe and list current medication.

Can you participate in the essential functions of your study abroad program without accommodation? ☐ Yes ☐ No
If No, what type of accommodation if required?

_____

_____

## TRAVEL DATES: PLEASE PROVIDE YOUR BEST ESTIMATION OF TRAVEL PLANS

| Date of flight leaving the U.S. _____ / _____ / _____<br>Date returning to the U.S. _____ / _____ / _____ | Travel Destination(s): |
|---|---|

## STUDENT ACKNOWLEDGEMENTS: COMPLETED BY STUDENT

**Please read each section carefully and sign below.**

### I. ACCURACY OF INFORMATION CONTAINED HEREIN

I hereby verify that all the information contained in this form is accurate and acknowledge that failure to provide accurate information may result in my dismissal from the program.

### II. EMERGENCY CARE WHILE ABROAD

I hereby consent to medical personnel designated or authorized by the Gonzaga University or administrator(s), in case of a medical emergency involving myself while attending the program to perform upon or administer any necessary medical or surgical treatment. In addition, I must personally consent to said medical procedure if I am physically and emotionally capable of consenting at the time such treatment is required. In the event Gonzaga University is required to rely on this consent to authorize necessary medical care and treatment, I, individually and jointly, agree to pay for treatment or reimburse Gonzaga University if it has paid for the treatment. I further agree to pay any costs and attorney fees if Gonzaga University has to sue me for repayment.

### III. ACCOMMODATIONS

The Study Abroad Office works to provide accommodations abroad for students who participate in study abroad. In this sense, our definition of accommodations is not limited to that of a disability as set by the Americans with Disabilities Act (ADA), but any adjustment to program or arrangement a student might need while abroad. This may include, but is not limited to: physical impairment(s), psychological conditions or mental impairment(s), students who are part of the LGBTQ+ community, and dietary restrictions or preferences. I understand it is my responsibility to disclose my needs as soon as possible by informing my Study Abroad Advisor. I am welcome to include an advocate in conversations with the Study Abroad Office to help disclose my needs.

### IV. ACKNOWLEDGEMENT OF INTERNATIONAL AVAILABILITY FOR MEDICATIONS

I am aware that particular prescription medications which I take may be or are unavailable in the country for this study abroad term. I understand that my choices include: talk to my doctor, look for an alternative medication that is available, cancel my plans before embarkation due to medical necessity with a full refund, look for a different study abroad country or program, or bring my choice of medication with me. If I choose to take medication with me, I understand that bringing on my trip any prescription medications that do not comply with local law could result in action against me by local authorities. I accept the consequences of this decision and understand that medical care is my responsibility and I will be subject to the laws of localities and countries in which I am traveling. I hereby release Gonzaga University from any responsibility for my medication decisions and acknowledge that I have acted independently in this decision.

### V. FUTURE MEDICAL PROBLEMS

Should you develop significant health problems between the time you have completed this form and commencement of the program, which may influence your participation in the program, I understand it is my responsibility to notify the Study Abroad Office at Gonzaga University. A medical report should accompany this notification.

### VI. TRAVEL VACCINATIONS

While my medical provider may recommend travel immunizations, I understand it is my responsibility to obtain the necessary immunizations for travel abroad. I have reviewed the vaccinations recommended by the Centers for Disease Control for my travel destination(s) located at the following link: http://www.cdc.gov/travel. I acknowledge that traveling abroad without receiving all of the recommended vaccines poses a potential risk to my health.

SIGNATURE: _____ DATE: ____ / ____ / ____

PROGRAM: _____ TERM: _____

STUDENT NAME: _____ DOB: _____ / _____ /_____

## IMMUNIZATION RECORD and EVALUATION: COMPLETED BY MEDICAL PROVIDER

| Routine Immunizations | | | | | |
|---|---|---|---|---|---|
| Vaccine Doses | MM-DD-YY | MM-DD-YY | MM-DD-YY | MM-DD-YY | MM-DD-YY |
| **POLIO**<br>(IPV: 4 doses recommended by age 6)<br>Or (OPV: 5 doses recommended by age 6) | 1. | 2. | 3. | 4. | 5. |
| **DIPHTHERIA-PERTUSSIS**<br>Tetanus (DTaP/Baby Shots) 5 Doses by age 6 | 1. | 2. | 3. | 4. | 5. |
| **TETANUS - DIPHTHERIA (DT) or (Td)**<br>Booster every 10 years | 1. | 2. | 3. | | |
| **MEASLES** (Rubeola)<br>2 doses | 1. | 2. | or Measles Serology:<br>Date:_____ Titer:_____ | | |
| **RUBELLA** (German Measles)<br>1 dose on or after 1st birthday | 1. | or Rubella Serology:<br>Date_____ Titer:_____ | | | |
| **MUMPS**<br>1 dose on or after 1st birthday | 1. | or Mumps Diagnosed by Physician<br>Date:_____ | | | |
| **MMR** (Measles, Mumps, Rubella)<br>If given instead of individual immunizations | 1. | 2. | | | |
| **HEPATITIS A** (Optional) | 1. | 2. | | | |
| **HEPATITIS B** (Optional) | 1. | 2. | 3. | | |
| **MENINGOCOCCAL** (Meningitis) | 1. | 2. | | | |
| **VARICELLA** (Chickenpox) | 1. | 2. | Or Chickenpox diagnosed by Physician<br>Date:_____ | | |
| **PPD - TUBERCULOSIS SKIN TEST**<br>(Only administer if required by student's program) | Date Read<br><br>mm Induration | | | | |

### Recommended Travel Vaccines

*After reviewing vaccinations recommended or required by the Centers for Disease Control for the study abroad destination(s), please indicate any travel vaccinations given below.*
*This may include, but is not limited to, Japanese encephalitis, Malaria prophylaxis, Rabies, Typhoid fever, Yellow fever, etc.*

| Vaccine | MM-DD-YY | Comments |
|---|---|---|
| | | |
| | | |
| | | |

STUDENT NAME: _____ DOB: _____ / _____ /_____

## PHYSICAL EXAM: COMPLETED BY MEDICAL PROVIDER

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

| EVALUATION OF SYSTEMS | | |
|---|---|---|
| System | Normal findings? | Description of Abnormalities |
| HEENT | ☐ Yes ☐ No | |
| Respiratory | ☐ Yes ☐ No | |
| Cardiovascular | ☐ Yes ☐ No | |
| Gastrointestinal | ☐ Yes ☐ No | |
| Endocrine | ☐ Yes ☐ No | |
| Musculoskeletal | ☐ Yes ☐ No | |
| Integumentary | ☐ Yes ☐ No | |
| Renal/Urinary | ☐ Yes ☐ No | |
| Lymphatic | ☐ Yes ☐ No | |
| Nervous System | ☐ Yes ☐ No | |

| | |
|---|---|
| Does this student have any history of allergy, anaphylaxis, or asthma? If yes, please explain: | ☐ Yes ☐ No |
| Is the student currently undergoing treatment for any medical condition? If yes, please explain: | ☐ Yes ☐ No |
| Does the student have any physical limitations that we should be aware of? If yes, please explain: | ☐ Yes ☐ No |
| Are you aware of any history of psychological disorders (i.e. depression, anxiety, eating disorders, etc.)? If yes, please explain: | ☐ Yes ☐ No |

Please include any additional information that you deem necessary in your assessment of the student's physical health.

_____

_____

_____

_____

_____

_____

STUDENT NAME: _____ DOB: _____ / _____ /_____

## MEDICAL CARE PROVIDER CLEARANCE: COMPLETED BY MEDICAL PROVIDER

*I have thoroughly reviewed the student's health, referring to the student's health history provided on this forms, and medical records on file. Based on this information, as well as my current observation of this student, to the best of my knowledge: (Initial one box below)*

*For more details on what each study abroad program entails, visit https://www.gonzaga.edu/academics/global-engagement/study-abroad/explore-study-abroad-programs.*

☐ Student is CLEARED. I have reviewed the patient's medical history. There are no medical or mental health contraindications to participation in this study abroad program. I have discussed with the student all vaccinations recommended by the Centers for Disease Control for their travel destination(s).

☐ Student is NOT CLEARED. There are medical or mental health contraindications to participation in the study abroad program that the student has chosen.

☐ Student is CLEARED with additional considerations. I have reviewed the student's medical history. I have discussed with the student all vaccinations recommended by the Centers for Disease Control for their travel destination(s). Additional considerations explained below.

Student requires an accommodation or support to assist in their medical/psychological conditions in order to participate in the study abroad program. Indicate and describe the treatment plan in place and comment on the student's stability.

_____

_____

_____

_____

_____

Printed Name: _____ Medical Degree: _____

Signature: _____ DATE: _____ / _____ / _____

Office Contact Information:

| | |
|---|---|
| Address: | |
| Phone Number: | Fax Number: |