COLLEGE OF
MOUNT SAINT VINCENT

Health Clearance Packet for CMSV Study Abroad Program

The following guidelines will assist you in completing clearance paperwork:

- **The Provider Clearance Form is the only portion of this packet that will be collected by the International Student Services (ISS) office. You are encouraged to share your Self-Care Plan with ISS but not required to do so.**
- Leaving any portion of the form blank will delay your health clearance.
- Only these official health clearance forms will be accepted by the ISS office; a narrative report on physician letterhead is **not** sufficient.
- The Provider Clearance Form must be completed by a health provider licensed in the U.S. and cannot be an immediate family member (AMA Code of Ethics E-8.19).
- Please make a copy of all completed health clearance forms for you records.

COLLEGE OF
MOUNT SAINT VINCENT

Health Clearance Packet for the Study Abroad Program

PART I: Personal Health History

Reminder: This form should be filled out by the student *before* appointment with provider. The completed form should be reviewed with provider during appointment.

Review of Symptoms and Illnesses

Please check "yes" if you have experienced any of the following diagnoses or symptoms. Please give details below on any checked response, adding additional paper if necessary.

	Yes		Yes		Yes
Abdominal problems		Depression / Anxiety		Substance use / abuse	
ADD/ADHD		Diabetes		Thyroid disorder	
Anemia		Eating Disorder		Vision / eye problem	
Arthritis		Epilepsy		Other (specify)	
Asthma		Gastrointestinal disorder			
Autism/ Asperger's		Head injury / concussion		**Allergy:**	
Back problems		Heart murmur / disease		Hay fever	
Bipolar Disorder		High blood pressure		Bees / wasps	
Bladder / kidney problems		Immune system problems		Pet / animal dander	
Bleeding / clotting disorder		Impaired use of limbs		Foods	
Blood disorder		Joint problems		Drugs	
Cancer or Leukemia		Learning disability		Other (specify)	
Celiac Disease		Migraines			
Cerebral palsy		Recurrent dizziness			

Be prepared to speak more about any condition(s) that you checked "yes" above.

A. Are you currently taking any medications? *If yes, list and give details.* **YES or NO**

_____

B. Have you ever been hospitalized? *If yes, give diagnosis and date.* **YES or NO**

_____

C. Do you have any permanent injury or physical disability? *If yes, explain.* **YES or NO**

_____

D. Do you have any health requirements or dietary restrictions? *If yes, explain.* **YES or NO**

_____

E. In the past two year, have you consulted or been treated for a mental health condition? *If yes, explain.* **YES or NO**

_____

COLLEGE OF
MOUNT SAINT VINCENT

Health Clearance Packet for Study Abroad Program

PART II: Clearance and Authorization

PROVIDER CLEARANCE FORM

Student's Name: _____

Health Care Provider Instructions – Please read carefully BEFORE signing form

1. The student must present to you a completed Personal Health History form (PART I). Please review for accuracy. A physical examination is not necessary.

2. Discuss/review the student's health history thoroughly referring to the Personal Health History form completed by the student AND the student's medical records on file, paying particular attention to medications and immunizations that the student may need, any allegories the student may have, and all currently active health problems.

3. If the student *is* cleared for travel abroad, they are required to create a Self-Care plan with your assistance. Both provider and student must verify that a Self-Care Plan was developed. Please consult PART III of this packet for instructions on developing a Self-Care Plan.

4. Students may be cleared for Study Abroad if

   i. in your opinion, as the examining practitioner, any medical or mental health condition they have is under control.

   ii. they have a contracted treatment plan in place; AND

   iii. they have been stable on their medication for a reasonable period.

Please Note:

- The student must complete required information on their Personal Health History form (Part I) prior to their appointment with you. Blank forms should not be accepted.
- It is especially important to consider the student's fitness and physical and mental health in relation to the country, the type of program, and the conditions in which the applicant will be living. Please encourage the student to provide this information verbally.
- If a specialist, including a therapist for a mental health issue, is seeing the student for an ongoing condition, each specialist must also approve and sign this clearance form.

COLLEGE OF
MOUNT SAINT VINCENT

Health Clearance Packet for Study Abroad Program

PART II: Clearance and Authorization

PROVIDER CLEARANCE FORM

Student's Name: _____

Licensed Physician / Nurse Practitioner / Physician's Assistant/Psychotherapist/Clinical Social Worker *
* Health care provider must be licensed in the US and cannot be an immediate family member.

OPTION 1:

☐ Student is **CLEARED**.

☐ I verify that a Self-Care Plan was developed during our appointment.

OPTION 2:

☐ Student is **NOT CLEARED:** There are medical and/or psychiatric contraindications to participating in the CMSV Study Abroad program.

Licensed Physician / Nurse Practitioner / Physician's Assistant, print name and title below:

_____

Phone Number: _____ Address: _____

Signature: _____ **Date:** _____

Please include stamp or business card below:

COLLEGE OF
MOUNT SAINT VINCENT

Health Clearance Packet for Study Abroad Program

PART III: Self-Care Plan

The Self-Care Plan is a document that is developed by the student with input from their health care provider. Additional resources, such as the CMSV Counseling Center, as well as websites listed in your orientation packet, are available for consultation as well.

A Self-Care Plan is a set of strategies to manage your health and wellbeing and to minimize the potential that a health issue will become a barrier to your learning experience.

A. Pre-Departure / Current Health Care Resources

Provider Information:

Name of Provider: _____ Specialty: _____

Phone Number: _____ Email: _____

Address: _____

How Often Provider is Seen: _____

Diagnosis / Health History Information:

Condition: _____ Date of Onset: _____

Symptoms: _____

Is the condition chronic or episodic (causing flares)? _____

Medication:

Name of Medication #1: _____ Dose: _____

Name of Medication #2: _____ Dose: _____

Name of Medication #3: _____ Dose: _____

Daily Life/ Activities of Daily Living:

Please describe how your condition c*an* interfere with daily life: _____

_____

Please list accommodations you currently use in your daily life: _____

_____

B. Resources Identified Abroad

If you are managing an acute or chronic medical, psychiatric, or psychological condition, it is imperative that you continue treatment abroad.

Recommended Treatment Regimen:

To keep myself healthy, it is best that I identify a _____ (specialty) health care provider:

a) To see once, at the time of arrival to me destination

b) To see on an ongoing and regular basis

C) To know about but not to see unless needed

Medication Planning:

	Medication 1	Medication 2	Medication 3
Name Of Medication			
Dosage			
Routine/Ongoing or As Needed?			
Available in destination?			
Do I need an RX?			
Can I bring a large supply through customs?			

Signs that My Conditioning is Worsening, Flaring or Destabilizing:

_____

_____

_____