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 _____ Preferred Name _____ Middle _____ Sex: M ☐ F ☐ Nonbinary ☐

Country/Program _____ Student ID _____

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, and 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_____

COVID-19 _____

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: _____