PEPPERDINE UNIVERSITY, INTERNATIONAL PROGRAMS

HEALTH FORM INSTRUCTIONS FOR STUDENTS STUDYING ABROAD

Office of International Programs
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STUDENT INSTRUCTIONS:

1. Make physical exam appointment with your personal physician or Pepperdine Student Health Center: 90 – 45 days before departure date.

2. Fill out Confidential Health History form PRIOR to appointment and discuss completed for in appointment.

3. Give the yellow copy of the Confidential Health History form to your physician.

4. Complete Health Clearance form with your physician during your appointment. You and your physician will sign the Health Clearance form and validate the document with the physician's stamp.

5. Return copy of signed Health Clearance form to IP office in person (TCC 131) or via email attachment to international.programs@pepperdine.edu, prior to 45 days before your departure.

6. Keep Confidential Health History form in your Emergency Envelope (see Student Handbook). Information may be used with your permission in the event that you require emergency medical treatment.

7. Review WaveNet To-do list (Health Clearance should be removed with 5-7 days)

TO THE PHYSICIAN OR HEALTH PRACTITONER:

The student named on the attached International Programs Health Clearance form has been selected to participate in Pepperdine's International Program (IP). Depending on the program, students may spend from a summer session up to a full year abroad. It is important that all students be able to adjust to potentially dramatic changes in stress, climate, diet, living and studying conditions that may be seriously disruptive to accustomed patterns of behavior.

This health clearance is required for all participating International Program students. The process includes the following steps:

1. The student must present to you a full completed Confidential Health History form.

2. Pay special attention to any emotional or psychological problems and any medications the student is taking.

3. Please impress on the student their need to take a sufficient amount of medication to last the duration of the International Program or ensure that medication is locally available.

4. Please list any physical or learning disabilities the student may have, and be sure to note the facilities or services required abroad on this form.

Students may be cleared for participation as long as, in the opinion of the examining practitioner, any medical condition they may have is under control and they have been stabilized on their medication for a reasonable period. If a specialist is currently seeing the student for a serious ongoing medical or psychiatric condition, the specialist must also approve and sign this clearance form.

AFTER EVALUATING THE STUDENT'S HEALTH, PLEASE COMPLETE THE HEALTH CLEARANCE FORM.

HEALTH CLEARANCE FORM FOR STUDENTS STUDYING ABROAD

Submit to IP office

The Physician or Health Practitioner must complete the following information after reviewing the student's Confidential Health History form with the student. For students seeing a specialist for a serious ongoing condition, the approval of the specialist must be obtained prior to review by the Physician or Health Practitioner.

_____ _____

Name of Student (please print) Program Abroad Term

PHYSICIAN/HEALTH PRACTITIONER:
I have read the attached information regarding the rigors of study abroad and have reviewed the student's Health History form with the student. Based on the information provided to me by the student on the Health History form and my thorough evaluation, I find:

☐ **There are NO medical or psychiatric contraindications to participation,** and the student is cleared to study abroad.

☐ **While the student is conditionally cleared to study abroad,** the student should arrange the following in advance of IP participation:

1. Services that would facilitate the student's education (e.g. note taking, wheel chair access). Student should contact the on campus Disability Services Office.
   _____
   _____
2. Services that would facilitate a healthy and safe stay (e.g. regularly available psychiatric therapy, allergy treatment, etc.).
   _____
   _____
3. Take a sufficient amount of medication to last for the duration of the program or ensure that medication is locally available. Indicate if significant allergy to any medication.
   _____
   _____

☐ **There ARE MEDICAL/PSYCHOLOGICAL concerns** that require a specialist referral for clearance to participate in the study abroad program.

☐ **There ARE MEDICAL contraindications to participation** and in my judgment the student is NOT cleared to study abroad.

☐ **There ARE PSYCHIATRIC contraindications to participation** and in my judgment the student is NOT cleared to study abroad.

Physician/Health Practitioner Signature & Stamp | Print name | Phone | Date

** If student is conditionally cleared, please have a specialist/psychotherapist evaluate further, sign and comment below with recommendations for either clearance or denial for study abroad:

_____
_____

Psychotherapist Signature & Stamp | Print name | Phone | Date

Specialist Signature & Stamp | Print name | Phone | Date

STUDENT:
I certify that I have had the required physical examination and provided the Confidential Health History form to a licensed physician. I agree to allow the medical provider to contact International Programs regarding concerning health matters.

_____

Student Signature Date

PEPPERDINE UNIVERSITY

CONFIDENTIAL HEALTH HISTORY FORM

Include in Emergency Envelope

All students must have health clearance in order to participate in an International Program. You must complete this form **before** attending your health clearance consultation. The yellow copy of this form is to be kept on file by the health care professional who performed your clearance. The white copy is yours to keep. You MUST bring your copy of this completed form abroad with you, which with your permission may be used if you require health-related treatment.

GENERAL INFORMATION: International Program_____ Student ID # _____

Print Name: Last _____ First_____ Middle_____ Sex M☐ F☐

Person to notify in case of emergency:

_____

(Name) *(Address)* *(Phone)*

HEALTH PROBLEMS:

List any continuing health problems: _____

List any physical or learning disabilities: _____

Are you currently under the care of a doctor or other health care professional, including mental health? ☐ Yes ☐ No

If so, who_____ Phone_____

Current condition? _____

MEDICINES:

List any medication/equipment you use regularly or anticipate using while abroad (indicate reason for use):_____

MEDICAL HISTORY: Check if you have ever had any of the following:

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Anemia				High blood pressure				Infectious mononucleosis			
Asthma/hay fever				Heart problems				Thyroid problems			
Back problem				Hepatitis/jaundice				Psychiatric problems			
Bladder/kidney problem				Protein/ sugar in urine				Migraine problems			
Epilepsy/convulsion				Ulcer/stomach problem				Alcohol problems			
Tuberculosis				Anorexia/bulimia				Substance abuse			

Previous surgeries_____ _____
(List type and year)

DRUG ALLERGIES: Check any drug allergies and briefly describe reaction:

____a. Penicillin_____ ____c. Sulfa_____

____b. Novocain/local anesthetic_____ ____d. other (specify) _____

IMMUNIZATION RECORDS: Check box if up to date

Polio immunization	☐	Mumps	☐
Last Tetanus/Tdap booster (given every 10 years)	☐	Measles	☐
Meningitis	☐	Rubella	☐
Hepatitis B (series of 3)	☐	MMR	☐
Hepatitis A (series of 2)	☐	Varicella	☐

WAVIER: I understand that the information on this form may be reviewed on a need to know basis by the appropriate medical personnel abroad in case of a medical emergency.

*Signature of Student*_____ Date_____

Certifies that the above information is complete and accurate.

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