

# PEPPERDINE UNIVERSITY, INTERNATIONAL PROGRAMS

## HEALTH FORM INSTRUCTIONS FOR STUDENTS STUDYING ABROAD

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. 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.
4. Return copy of signed Health Clearance form only to IP by uploading it to the [Vital Document Submission Form](#) (link also available on the IP Prepare page) at least 45 days before your departure.
5. Keep your 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. Do not send the confidential health history form to International Programs.

### TO THE PHYSICIAN OR HEALTH PRACTITIONER:

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 comprehensive 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 BY SIGNING, DATING, AND PUTTING A STAMP ON THE FORM.**

# HEALTH CLEARANCE FORM FOR STUDENTS STUDYING ABROAD

## SEND ONLY THIS PAGE TO INTERNATIONAL PROGRAMS

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 campus' Student Accessibility 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.

\_\_\_\_\_  
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

Submit to IP office

# PEPPERDINE UNIVERSITY

## STUDY ABROAD CONFIDENTIAL HEALTH HISTORY FORM

**DO NOT SEND THIS FORM TO INTERNATIONAL PROGRAMS**

All students must have a health clearance in order to participate in an International Program. Complete this form **before** attending your health clearance consultation. 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 CONCERNS:**

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:** \_\_\_\_\_

**IMMUNIZATION RECORDS:** Check box if up to date

- |                                                  |                          |           |                          |
|--------------------------------------------------|--------------------------|-----------|--------------------------|
| Polio immunization                               | <input type="checkbox"/> | Mumps     | <input type="checkbox"/> |
| Last Tetanus/Tdap booster (given every 10 years) | <input type="checkbox"/> | Measles   | <input type="checkbox"/> |
| Meningitis                                       | <input type="checkbox"/> | Rubella   | <input type="checkbox"/> |
| Hepatitis B (series of 3)                        | <input type="checkbox"/> | MMR       | <input type="checkbox"/> |
| Hepatitis A (series of 2)                        | <input type="checkbox"/> | Varicella | <input type="checkbox"/> |

**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.*