



CISP Health Clearance for Students Planning to Study Abroad

1. **Review Student’s Confidential Health History Form and medical records on file, with the student and discuss/review the student’s health history thoroughly.** After review, the Physician/Health Practitioner must carefully AND LEGIBLY complete this form; otherwise, the process may be delayed.
2. **For students seeing a specialist for an ongoing condition,** the approval and signature of the specialist (s) must be obtained before final clearance is signed by the Physician or Health Practitioner.
3. **Legible names of the physician and the specialist, if student is seeing one, are required.** FORMS WITHOUT SIGNATURES AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE and will delay the student’s compliance with CISP requirements.

PLEASE PRINT CLEARLY WITH A BALL POINT PEN. ALL LINES AND APPLICABLE BOXES MUST BE COMPLETED

First and Last Name of Student

ASU Campus ID

CIS Program Name (Term/Host University/Country)

I have read the attached information about the rigors of study abroad and have reviewed the student’s Confidential Health History form and medical records on file, with the student. Based upon the information provided to me by the student on the Confidential Health History form, and pursuant to a review of the student’s personal health history, to the best of my knowledge the student is:

Licensed Physician/Health Practitioner*

- Conditionally cleared to study abroad:** Student should arrange the following before CISP participation:
 - 1a. Services that would facilitate the student’s education (e.g. note taking, wheel chair access). Student should contact the Student Life Office for a letter documenting disability and who will pay for services.
 - 1b. Current need for services that would facilitate a healthy and safe stay abroad (e.g. regularly available psychiatric therapy, English-speaking therapist with expertise on eating disorders, etc.). Indicate that student is stable.
 - 1c. Discussed with student to take enough medication to last through CISP or ensure that the medication is locally available and legal.
- Unconditionally cleared to study abroad:** There are NO medical or psychiatric contraindications to CISP participation.
- Student is NOT cleared to study abroad:** There are **medical contraindications** to CISP participation.
- Student is NOT cleared to study abroad:** There are **psychiatric contraindications** to CISP participation.

Licensed Physician/Health Practitioner (M.D., N.P.,P.A., or R.N): PLEASE PRINT CLEARLY OR STAMP BELOW

Signature (required) _____

Name/Title: _____

Telephone: (_____) _____ Date: _____

Address: _____

**Physician/Health provider/specialist must be licensed in the U.S. and cannot be an immediate family member (AMA Code of Ethics e-8.19)*

Licensed Specialist/Psychotherapist* (Section and Signature required if checked)

1. **Conditionally cleared to study abroad:** Student should arrange the following before CISP participation.

- 1a. Services that would facilitate the student's education (e.g. note taking, wheel chair access). Student should contact the Student Life Office for a letter documenting disability and information about who will pay for the services.

- 1b. Current need for services that would facilitate a healthy and safe stay abroad (e.g. regularly available psychiatric therapy, English-speaking therapist with expertise in eating disorders, etc.). Indicate that student is stable.

- 1c. Discussed with student to take enough medication to last through CISP or ensure that the medication is locally available and legal. If student is on medication, please list. Also, indicate if significant allergy to any medication.

- Unconditionally cleared to study abroad:** There are NO medical or psychiatric contraindications to CISP participation.
- Student is NOT cleared to study abroad:** There are **medical contraindications** to CISP participation.
- Student is NOT cleared to study abroad:** There are **psychiatric contraindications** to CISP participation.

Licensed Specialist/Psychotherapist: PLEASE PRINT CLEARLY

Signature (required) _____

Name/Title: _____

Telephone: (_____) _____ **Date:** _____

Address: _____
