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 LEGIBILY 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*

☐ **Student is CLEARED -** No medical or mental health contraindications to participation in a study abroad program.
☐ **Student** needs to be evaluated by a specialist.
☐ **Student is CONDITIONALLY CLEARED** (Check all that apply below)

☐ 1.a Student requires services to facilitate participation in the academic program (e.g., note-taking, wheelchair access). Student should contact the Student Life Office for a letter documenting disability and who will pay for services.

_____

☐ 1.b Student requires services to facilitate a healthy and safe stay abroad (e.g., regularly available psychiatric therapy, etc.) Indicate that student has treatment plan in place and is stable.

_____

☐ 1.c Student requires a sufficient supply of medication to last through the duration of the study abroad program student has chosen and must ensure that the medication is available and legal.

_____

☐ 1.d Student has a significant allergy to certain medication(s) and/or certain food(s). Please list:

_____

☐ **Student is NOT CLEARED**: There are medical or mental health contraindications to participation in a study abroad program.

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: _____

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. **Student is CLEARED -** No medical or mental health contraindications to participation in the study abroad program student has chosen.

☐ **Student is CONDITIONALLY CLEARED** (Check all that apply below)

- ☐ 1.a Student requires services to facilitate participation in the academic program (e.g., note-taking, wheelchair access). Student should contact the Student Life Office for a letter documenting disability and who will pay for services.

  _____

- ☐ 1.b Student requires services to facilitate a healthy and safe stay abroad (e.g., regularly available psychiatric therapy, etc.) Indicate that student has treatment plan in place and is stable.

  _____

- ☐ 1.c Student requires a sufficient supply of medication to last through the duration of the study abroad program student has chosen and must ensure that the medication is available and legal.

  _____

- ☐ 1.d Student has a significant allergy to certain medication(s) and/or certain food(s). Please list:

  _____

☐ **Student is NOT CLEARED**: There are medical or mental health contraindications to participation in a study abroad program.

Licensed Specialist/Psychotherapist: PLEASE PRINT CLEARLY OR STAMP BELOW

Signature (required) _____

Name/Title:_____

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

Address: _____

_____

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