UCEAP
Annual Health Update
SUMMER 2015 – SPRING 2016 PROGRAMS
Country Specific Health Requirements

Revision History:
2/9/2015 - Inside cover: Changes to the UCEAP Program Specialist assignments.
4/15/2015 - Inside cover: Changes to Program Specialist assignments.
### QUESTIONS?

**About Country or Host Institution Specific Requirements, Deadlines, or Students, call:**

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<th>Czech Republic, Denmark, France, Germany, Italy, Netherlands, Russia, Sweden, Switzerland</th>
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<td><strong>Kitty Christen</strong>, International Program Specialist, Operations......................(805) 893-4430</td>
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<td><em>(Argentina, Barbados, Brazil, Chile, Multi-City Program: Santiago/Buenos Aires)</em></td>
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<td><em>(Costa Rica, Dominican Republic, Mexico, Multi-City Program: Barcelona/Istanbul/Florence, Spain)</em></td>
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**About UCEAP Health Clearance, UCEAP Insurance, and Student Medical Cases, call:**

| **Inés DeRomaña**, Director | (805) 893-7936 | ideromana@eap.ucop.edu |
| **Nancy Osborne**, Analyst | (805) 893-3304 | nosborne@eap.ucop.edu |
| **UCEAP Insurance Liaison** (goes to both Inés and Nancy) | uceapinsurance@eap.ucop.edu |
Annual Update of UCEAP Program-Specific Health Requirements

To: Campus Student Health Services and Campus EAP Offices

From: University of California, Education Abroad Program (UCEAP) Systemwide Office

Re: 2015–2016 medical requirements and recommendations and the UCEAP health clearance process

Please read this memo as it includes new information and serves as reminder of specific protocols.

- Refer to the electronic version of this document for the most updated information. We will send email updates whenever the electronic version is modified. www.eap.ucop.edu/Documents/HealthClearance/1516/annual_health_update.pdf

- **Need supplies?** If you need **confidential health history** or **Health Clearance** forms, email HSER@eap.ucop.edu and indicate the number of forms that you need.

**REQUIRED UCEAP CONFIDENTIAL HEALTH HISTORY FORM (See Appendix for sample)**

- Students must complete a paper or online **confidential health history** form according to their campus instructions before their health consultation. Carefully review the completed form.
- **Keep a COPY** for your files, and **return a COPY** to the student.
- Advise students to take a copy of the completed form abroad in case of an emergency.
- Advise students NOT to send a copy of the confidential form to the UCEAP Systemwide Office.

**REQUIRED UCEAP HEALTH CLEARANCE FORM (See Appendix for sample)**

- The University of California aims to facilitate a safe and smooth treatment transition for students currently in treatment.
- Read the **UCEAP Health Clearance** form instructions carefully.

> Many forms arrive without the student’s name and/or complete program information. This causes a delay. The licensed health practitioner completing the form should verify the following before clearing the student and signing the form.

- [ ] The student’s name, campus and program (including Country, Host University and Term) should be filled in.
- [ ] Signatures, contact information, and the clearance decision of all health providers who are treating the student must appear on the form. Additional forms can be attached if the student is being treated by multiple specialists.
- [ ] All three pages of the triplicate form must be legible (if using the paper form).

Incomplete or incorrectly completed forms may be returned to the clearing practitioner or student. Keep a **COPY** for your files, and return the rest to the student.
REQUIRED PROGRAM-SPECIFIC MEDICAL TESTS AND HEALTH RECOMMENDATIONS

Some programs require medical tests and/or have special health recommendations. These requirements and recommendations are indicated in the country-specific section of this document.

Refer to the electronic version of this document during the year for the most updated information. We will send e-mail updates whenever the electronic version is modified.

Program-specific forms provided in the Appendix are samples only. The UCEAP Systemwide Office will send specific instructions and official forms to students.

REQUIRED UCEAP ONLINE TRAVEL HEALTH COURSE

UCEAP plans to transition to a new online Travel Health Course that is currently being finalized. Beginning with Summer 2015 programs, students in programs requiring the online Travel Health Course will receive instructions to access and complete the online course.

Students participating in 2015-16 UCEAP programs in the following countries are required to complete the online Travel Health Course: Argentina, Barbados, Botswana, Brazil, China, Costa Rica, Dominican Republic, Ghana, India, Indonesia, Jordan, Mexico, Morocco, Russia, Senegal, South Africa, Tanzania, Thailand, Turkey, and Vietnam.

FYI: Student instructions to access the online Travel Health Course are in the UCEAP Pre-departure Checklist (PDC).

RECOMMENDED DISCUSSION TOPICS FOR IN-PERSON HEALTH CLEARANCE APPOINTMENTS BASED ON UCEAP STUDENT INCIDENT TRENDS

The UCEAP Systemwide Health, Safety & Emergency Response unit coordinates, manages and tracks student incidents and cases abroad. Based on trends, we know that some students do not follow recommended treatment plans or maintain adequate health management while on UCEAP programs.

UC student health practitioners have an opportunity during in-person health consultations to provide advice and mentorship. Consider the following topics, as appropriate for the student and their destination(s):

- Recommendation to get all necessary vaccinations while enrolled in campus insurance - the UCEAP travel insurance DOES NOT cover vaccinations, physical exams, or other preventive care.
- Medication management (see below)
- Alcohol and drug use (see below)
- Psychological health (see below)
- Physical, psychological or learning disabilities (see below)
- The importance of identifying support systems, including UCEAP and campus staff and resources
- Recommendation to make a travel clinic appointment
**RECOMMENDED VACCINES**

- **Seasonal Flu**: Influenza is one of the most common ailments for UCEAP students. Students are frequently in crowded places and regularly take crowded public transportation. The UCEAP Physician Consultant recommends flu vaccination for all students, and *strongly* recommends it for:
  - Those who will be abroad during the fall or winter
  - Those with any chronic medical condition

- **Bacterial Meningitis**: Students planning to live in dormitories should be vaccinated against Meningococcal disease.

- **Measles** remains a common disease in many parts of the world, including Europe, the Middle East, Asia, the Pacific, and Africa. Students who have not been vaccinated are at risk of getting the disease and spreading it to others.

  *FYI: The UCEAP insurance does *not* cover vaccinations, but the UC or campus SHIP and/or student’s private insurance may.*

**UCEAP TRAVEL INSURANCE**

All students will be automatically covered by UCEAP travel insurance while abroad. Here are some key facts about this coverage:

- Benefits start **14 days before** the official start of the student’s UCEAP program and end **31 days after** the official end of the student’s UCEAP program.
- The UCEAP insurance does **not** cover preventive care, including vaccinations and physical exams.
- The UCEAP insurance will reimburse students for malaria prophylaxis if it is prescribed by a doctor and filled, picked up, and paid for within the term of coverage (i.e. no more than 14 days prior to the official start-date of the UCEAP program).
- Prescription medications are covered only if they are filled, picked up, and paid for within the term of coverage.
- Students **pay upfront** and submit a claim for reimbursement for eligible medical services and prescription medications.

Students can be directed to the ‘Insurance’ tab of their Pre-departure Checklist (PDC) for additional information about the UCEAP travel insurance. Questions can also be sent to the **UCEAP Insurance Liaison** ([uceapinsurance@eap.ucop.edu](mailto:uceapinsurance@eap.ucop.edu)).

**IMPORTANT INFORMATION ABOUT MEDICATION AND ALLERGY MANAGEMENT**

**Allergies**: A medical alert ID bracelet or pendant is recommended for students with medical conditions including diabetes; asthma; serious (anaphylactic) allergies; or any other condition that could have severe consequences if they are unable to communicate during a health emergency.

**Prescription Medications:**

- Although medications in amounts clearly related to personal use for the expected duration of a trip (30 days) are rarely inspected or questioned, customs officials can be suspicious of medications, particularly if students are traveling with large amounts. In some countries, drugs that are legal and readily available in the U.S. are considered illegal, require a prescription, or arouse the suspicions of local officials and customs and immigration authorities.
• Explain to students that prescribed medication regimens are important to their health and well-being and that they should never abruptly discontinue their medication, especially abroad.

• UCEAP cannot maintain a list of prescribed (or OTC) medications and their legality in the different countries. It is the student’s responsibility to get this information before departure.

• Students must:
  o Keep medicines in their original, labeled, pharmacy packaging when possible. The label should include the student’s name.
  o Obtain and carry a letter from the prescribing physician on letterhead, appropriately signed and dated, stating diagnosis, treatment, and medication regimen, including the generic name.
  o Review medication regulations on the INCB website and official government sites if they take medications containing controlled substances (including amphetamine-based medications). Excerpted national statutes for most countries can be found at www.incb.org/incb/en/psychotropic-substances/travellers_country_regulations.html. Also, refer students to their UCEAP Program Guide.
  o Students with diabetes and those who use injectable medications should obtain and carry at all times a doctor’s letter explaining the need to carry needles and syringes.

**About Mailing Medications Abroad:**

• Many countries have strict laws about mailing medications. The local Customs Office regulates this; not the U.S. Post Office or any global courier. Students often find that common medications in the U.S., including oral contraceptives and vitamins, get stopped by the host country's customs officials.

• Many students, and their parents, have found out the hard way that their medication is stopped by customs officials. The U.S. Post Office also restricts using the U.S. postal system to mail medications. Prescription medications can only be mailed by Drug Enforcement Administration (DEA) registered entities. Similar regulations may apply to over-the-counter medications.

• Do not advise students to mail any type of pharmaceuticals to other countries.

**ALCOHOL AND DRUGS**

**IMPORTANT:** Alcohol and drug use has had significant impacts on UCEAP students including arrest, hospitalization, victimization, eviction, disciplinary actions, and academic consequences. Ask students directly about their alcohol and drug use patterns to detect at-risk or problem drinkers so you can advise them appropriately.

Students will be subject to the laws of their host country regarding possession and consumption of alcohol, marijuana, narcotics, prescription medications, and other illegal substances. In some countries alcohol is limited or outlawed because of religious practices. In other countries alcohol is readily available, and the alcohol content may be higher than in the U.S.

The risks posed by excessive drinking and intoxication are as present in education abroad programs as they are on UC campuses.

UCEAP follows University of California substance abuse policies while students are abroad. Students who violate UCEAP’s substance abuse policy may be dismissed.
PSYCHOLOGICAL HEALTH

- Pay special attention to any emotional or psychological issues that are disclosed by the student, or that are indicated by medications the student is taking.
- Preexisting emotional difficulties are often intensified by the stress of living in a foreign culture.
- Decompensation is a serious health and safety concern abroad.

- **Not all countries have mental health support services or treatment facilities similar to those in the U.S.** Help students who need continued treatment or other specific support to have a written plan. Consider creating a safety health plan with the student that the student will find appropriate resources abroad and establish sufficient support systems before departure. Contact Inés DeRomaña (ideromana@eap.ucop.edu) at the UCEAP Systemwide Office for a sample plan.
- Advise students to communicate with UCEAP before departure so we can work with the student to arrange appropriate treatment and reasonable accommodations abroad.

  **NOTE:** Confidential information that the student relays to UCEAP remains confidential and will be shared with UCEAP officials only on a ‘need to know’ basis. The information will only be disclosed to those in a position to help.

- Consider asking students who have a history of substance abuse and/or psychological health issues to sign a limited authorization to disclose health information to UCEAP. This will help UCEAP, UC student health services, and the host university student services to work together if the student is in distress. You can find a sample in the Appendix.

  **FYI:** Many UCEAP Study Centers abroad maintain lists of English-speaking mental health counselors. Students often get this information during on-site orientation. They can always contact their UCEAP Representative abroad for recommendations and assistance.

STUDENTS WITH DISABILITIES

- Students must provide the UCEAP International Program Specialist with an accommodations letter from the campus Disability Office.
- Students should carry with them medical documentation of their disability and a copy of the accommodations letter from their campus Disability Officer.
- Some host institutions will require medical documentation and diagnosis directly from the student to provide accommodations. Other host institutions may not be able to provide certain accommodations.
- UCEAP does not fund accommodations abroad.

Environmental, socioeconomic, and cultural factors influence attitudes towards people with disabilities. Advise students to:

- expect differences and to be flexible,
- research attitudes that are prevalent in their destination about people with disabilities, and
- talk with others about potential challenges and support systems they will use if those challenges materialize during their study abroad experience. For more information, refer the student to the UCEAP website, Students with Disabilities portal.
# COUNTRY AND HOST UNIVERSITY HEALTH REQUIREMENTS

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# COUNTRY AND HOST UNIVERSITY SAMPLE HEALTH FORMS

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ARGENTINA

Required by Government: -0-  Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

AUSTRALIA

Required by Government:

When applying for the mandatory student visa—an electronic application process—some students, depending on their length of stay and other factors, will be required by the Australian Department of Immigration to undergo a medical exam and chest X-ray. **In such cases, the Australian embassy will give students instructions to download the specific and required medical forms needed for submission.** These forms must be completed by a physician and returned to the Australian embassy in Washington, D.C.

Required by Host University: -0-

BARBADOS

Required by Government: YFI, if arriving from or transiting for more than 12 hours through countries with YF transmission risk.

Required by Host University: Univ. of the West Indies Confidential Medical Questionnaire (see Appendix).

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

BOTSWANA

Required by Government: YFI, if arriving from or transiting for more than 12 hours through countries with YF transmission risk.

Required by Host University: -0-

Required by CIEE: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Malaria prophylactic pills—all students must:
   - sign a Malaria Prophylaxis Participation Agreement (see Appendix), and
   - purchase antimalarials before leaving the U.S. (See Pg. 3 ‘UCEAP Student Insurance’ for coverage details that apply to antimalarial medication.)

2. Successful completion of the UCEAP online Travel Health Course

BRAZIL

Required by Government: -0-  Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.
CANADA

*Required by Government:* -0-  
*Required by Host University:* -0-

CHILE

*Required by Government:*

**Chile has two consulates in California, located in San Francisco and Los Angeles.** Students must apply for their visa at the consulate closest to their UC campus. The consulates have different health clearance timing requirements, as follows:

- The consulate in Los Angeles requires that the health clearance be completed and signed 30 days or fewer before the visa application.
- The consulate in San Francisco requires that the health clearance be completed within six months of the visa application. Despite this flexibility, UCEAP recommends that the clearance be done within three months of the visa appointment.

**Both Chilean consulates require:**

- The **original, manually-completed, triplicate** UCEAP Health Clearance form (see Appendix for sample form) **signed by an MD** whether an FNP, NP or PA performs the clearance.
  - The doctor’s name **and** title must be clearly and carefully printed on the form, along with contact information including phone number, address and e-mail address.
  - The form must bear the official stamp of the medical facility for each physician signing the form. A validation stamp or business card will suffice.

Forms that *do not* conform to this requirement will be returned, which will delay the visa process.

*Required by Host University:* -0-

**IMPORTANT HEALTH ADVICE:** Severe air pollution exists in Santiago, especially during the winter months of May through August. Students with emphysema, asthma, and bronchitis should prepare for an increase in respiratory symptoms.

CHINA, PRC

*Required by Government for all programs in China:*

YFI, if arriving from or transiting through countries with YF transmission risk.

*Required by Government for students who will be in China for more than six months:*

- Students who will be in China for more than six months are required to apply to extend their residency within 30 days of their arrival in China. This includes students in the Beijing Normal University (BNU) Summer+Fall, Peking University (PKU) Year, and some students in back-to-back programs at different Chinese universities.

  **NOTE:** If a student is participating in back-to-back programs in China, they should contact UCEAP International Program Specialist May Pothongsunun at (805) 893-6152 or mpothongsunun@eap.ucop.edu to find out if their program combination will exceed six months and whether or not they will need to complete the Physical Examination Record for Foreigner.

- A thoroughly completed and properly stamped Physical Examination Record for Foreigner (see Appendix for notated sample form) must be submitted with the residency extension application.

  *Continued on next page.*
Each student required to apply for extension of residency has the option to complete the physical
exam and the required lab work in the U.S. as part of the UCEAP Health Clearance process—or—to
wait until after arrival in Beijing. Factors for the student to consider include:

- Time frame: The exam and lab tests must be completed no more than six months prior to
  arrival in China; otherwise, it will be considered invalid.
- Potential costs associated with the exam: Students will pay approx. $70 (U.S.) to have the
  exam done in Beijing. Students who have the exam done in the U.S. will pay the exam cost in
  the U.S. (varies by physician and insurance) plus an additional $10 (U.S.) to have the results
  verified by the Beijing Physical Exam Facility, operated by the National Quarantine Bureau. If
  the form and lab results are not accepted for any reason (this can be arbitrary), the student
  will pay to have the exam re-done in Beijing.
- Potential costs associated with the exam results: Students who return positive test results for
  diseases listed on the form may not be granted a residency extension and may be required to
  leave China.

Use the following instructions and the notated sample form in the Appendix if a student requests to
have the physical exam done at Student Health Services (SHS):

**PHYSICAL EXAMINATION RECORD FOR FOREIGNERS - INSTRUCTIONS:**

1. Students must use the form provided to them by UCEAP (See Appendix for notated sample form).
2. Complete all boxes; do not leave any section blank.
3. All original lab exam results attached to the form (e.g. blood tests, X-rays, etc.) must be clear and
   specific and bear the official* stamp of the laboratory completing the exam. Do not submit lab
   results marked, “COPY.” Students will be required to retake tests if lab results are illegible or
   improperly stamped.
   *If no other stamp is available, use an address stamp that includes the name of the UC SHS or lab.

**PAGE 1**

4. Follow detailed instructions on notated sample form (see Appendix).
5. Use metric measurement units where indicated.
6. If health indicators listed on the bottom half of Pg. 1 (e.g. development, nourishment, skin, nose)
   are within normal ranges, write “normal” in each box.

**PAGE 2**

7. If test results are negative, write “negative.”
8. Write Chest X-ray results in the box indicated and attach the original, stamped lab report.
   Original X-ray films are not required.
9. Attach original TB lab results (stamped by UC SHS or lab). Students with active TB will not be
   allowed into China.
   - A positive TB skin test requires negative chest X-ray results.
   - Original chest X-ray films are not required, but a printed report is required.
10. Write ECG results in the box indicated and attach the original printout results (stamped by UC SHS or
    lab).

*Continued on next page.*
11. Clearly label and write test results for HIV and Syphilis in the box indicated.
   - The original blood test reports must be included for both AIDS and Syphilis. The Chinese government will not accept a photocopy of the HIV test result.
   - If test results are not clearly marked as negative, the student may be required to get another health exam in China.

12. Write “None found” in the box labeled “None of the following diseases or disorders found during the present examination” unless evidence of one of the listed diseases was, in fact, found.

13. Write “None” if you have no suggestions for the student.

14. Sign and date where indicated.

15. Stamp both pages of the Physical Examination Record for Foreigner with the official stamp of the UC SHS or private physician completing the form:
   - on the student’s photo on Pg. 1, and
   - near the physician’s signature on Pg. 2.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT HEALTH ADVICE: Air pollution is a significant problem in many cities and regions in China. Pollutants such as particle pollution and ozone are linked to a number of significant health effects, and those effects are likely to be more severe for sensitive populations, including people with heart or lung disease. Students should purchase N95 respirators (masks) in the U.S. to wear during days considered hazardous to health.

COSTA RICA

Tropical Biology Programs (Monteverde Fall and Spring)

Required by Government: YFI, if arriving from or transiting for more than 12 hours through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT INFORMATION ABOUT THE PROGRAM:

- Students must be prepared mentally and physically for a fairly stressful 11 weeks.
- Students will spend 11 weeks in tropical rain forest, dry forest, and coastal areas. The program includes strenuous outdoor activities (e.g., camping, hiking, snorkeling, and backpacking through mountainous tropical forests). Individual research projects involve forests, fields, ocean, streams, animals or insects, and take place during the day and night.

Continued on next page.
The academic and research work and study field trips in remote locations are demanding.

Students camp, receive instruction outdoors and live in close quarters in biological field stations.

Group dynamics are extremely important. Students must be able to manage well within a group.

Access to medical attention: Although reliable medical services are available throughout Costa Rica and its outlying provinces, students will be living in a rural tropical environment. Some program activities occur in remote places. The remote locations may be many days from medical facilities. Communication and transportation are difficult and evacuations and medical care may be significantly delayed. Examples of transportation to medical facilities: 1) About 30 minutes by boat, and another 30 minutes by car. Student could be stabilized here and if necessary transported to a major hospital near San Jose by car or by plane/helicopter. 2) Student would walk, get taken out by horseback or carried on a rescue board to the Monteverde Cloud Forest Reserve (14 km. At best 3 hours or so by horse). From there, student would get taken to clinic in Monteverde (10 minutes), evaluated, treated, stabilized and possibly evacuated to San Jose (3.5 hours).

Czech Republic

Required by Government: -0-

Required by Host University: -0-

Denmark

Required by Government: -0-

Required by Host University: -0-

Dominican Republic

Required by Government: -0-

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

Important Information About the Program:

Students will spend six weeks in Santiago followed by one week in a rural community, where Malaria transmission rates may be higher.

France

Required by Government: A medical exam is given after arrival in France for the purpose of the residence permit for students with semester- or year-long visas. The exam is non-invasive (no blood work), but includes an X-ray to screen for TB.

Required by Host University: -0-

Germany

Required by Government: -0-

Required by Host University: -0-
GHANA

Required by Government: YFI required for students arriving from all countries. The International Certificate of Vaccination should be affixed to the visa inside of the student’s passport and presented at the port of entry in Ghana.

Required by Host University: Malaria prophylactic pills—all students going to University of Ghana must:
- sign a Malaria Prophylaxis Participation Agreement (see Appendix), and
- purchase antimalarials before leaving the U.S. (See Pg. 3 ‘UCEAP Student Insurance’ for coverage details that apply to antimalarial medication.)

Required by UCEAP and the UCEAP Physician Consultant:
1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT HEALTH ADVICE: Many UCEAP students were hospitalized with uncomplicated malaria. It is uncertain whether they stopped their prophylaxis regimen or failed to follow personal protective measures against bites. Help students understand about malaria prevention.

IMPORTANT INFORMATION ABOUT THE PROGRAM:
- Programs in Ghana have a long duration (greater than three months).
- Students may participate in visits to rural communities.

HONG KONG

Required by Government: -0-
Required by Host University:

The CUHK health form does not require special medical tests or physician signatures. CUHK will include the official form in their admission packet (see Appendix for sample form).

HKU and HKUST have no university health forms.

IMPORTANT INFORMATION ABOUT THE PROGRAM:
- The HKU Global Business in Asia summer program includes a required two week field trip to Shanghai, China.

INDIA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Jamia for International Summer School, New Delhi: -0-
Required by Alliance for Internship & Research, Pune: -0-
Required by CIEE for Univ. of Hyderabad: -0-

Required by UCEAP and the UCEAP Physician Consultant:
1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT HEALTH ADVICE: Air pollution is a significant problem in many cities in India, including New Delhi, Mumbai, Hyderabad and Pune. Students with a history of emphysema, asthma and chronic bronchitis should prepare for an increase in respiratory symptoms.
INDONESIA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT INFORMATION ABOUT THE PROGRAM: The program includes required field trips in the Yogyakarta area.

IRELAND

Required by Government: -0-          Required by Host University: -0-

ISRAEL

Required by Government: -0-

Required by Host University:

**Ben-Gurion University:** The BGU Medical Form can be replaced with the usual UCEAP Health Clearance form. Students will need two legible copies of the UCEAP Health Clearance form if the BGU Medical Form is replaced.

**Hebrew University:** Complete physical examination including urinalysis. *Hebrew University Report of Medical Examination* must be completed and results of any lab work noted on the form (see Appendix).

ITALY

Required by Government: -0-          Required by Host University: -0-

JAPAN

Required by Government: -0-

Required by Host University: Certain host universities require a health form (see Appendix for samples).

All tests indicated on the host university form are required and must be done within three months of application to the university.

**Japanese health form required for:**
- Doshisha University
- Hitotsubashi University
- International Christian University (ICU)
- Keio University
- Tohoku University

**Japanese health form not required:**
- Meiji Gakuin University
- Osaka University
- Tsuru University
- Waseda University
- University of Tokyo

**IMPORTANT: MEDICATION**

Japan has strict rules and stiff penalties regarding importation of prescription medications. Students are advised in their UCEAP Program Guide to go to [http://www.uctsc.org/YakkanShomei.html](http://www.uctsc.org/YakkanShomei.html) for details.
JORDAN

**Required by Government:** YFI, if arriving from or transiting through countries with YF transmission risk.

**Required by Host University:** -0-

**Required by UCEAP and the UCEAP Physician Consultant:**

1. Successful completion of the UCEAP online Travel Health Course.

KOREA

**Required by Government:** -0-

**Required by Host University:** -0-

**Required by Host University Housing:** TB test results on a medical report. Students must submit the test results within 2 weeks of arrival. There is no actual form. This is only applicable to students who will reside in SK Global House or International House and can be done after arrival in Korea.

MEXICO

**Required by Government:**

Statement of good health to be provided by campus Student Health Services or a private physician: This can be a photocopy of the UCEAP Health Clearance form, or a letter stating that the student is in good health.

**Required by Host University:** -0-

**Required by UCEAP and the UCEAP Physician Consultant:**

1. Successful completion of the UCEAP online Travel Health Course.

**IMPORTANT HEALTH ADVICE:** Acute respiratory infections are a common cause of illness in Mexico and are aggravated by Mexico’s air pollution. Extreme conditions can occur in Mexico City and Guadalajara, especially from December to May.

MOROCCO

**Required by Government:** -0-

**Required by Host University:** -0-

**Required by UCEAP and the UCEAP Physician Consultant:**

1. Successful completion of the UCEAP online Travel Health Course.

**IMPORTANT HEALTH ADVICE:** Morocco’s climate varies by region, becoming more extreme in the interior. Desert climate in portions of this country may aggravate respiratory conditions.

MULTI-CITY PROGRAMS (Madrid/Rome and London/Paris)

**Required by Government:** -0-

**Required by Host University:** -0-
### MULTI-CITY PROGRAM (Istanbul/Florence/Barcelona)

<table>
<thead>
<tr>
<th>Required by Turkish Government: -0-</th>
<th>Required by Host University: -0-</th>
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<tbody>
<tr>
<td><strong>Required by UCEAP and the UCEAP Physician Consultant:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Successful completion of the UCEAP online Travel Health Course.</td>
<td></td>
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<tr>
<td></td>
<td><em>Select ‘Turkey’ as the country to which you are traveling.</em></td>
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</tbody>
</table>

### MULTI-CITY PROGRAM (Buenos Aires/Santiago)

<table>
<thead>
<tr>
<th>Required by Government: -0-</th>
<th>Required by Host University: -0-</th>
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<tbody>
<tr>
<td><strong>Required by UCEAP and the UCEAP Physician Consultant:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Successful completion of the UCEAP online Travel Health Course.</td>
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<tr>
<td></td>
<td><em>Select ‘Argentina’ as the country to which you are traveling.</em></td>
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</table>

### NETHERLANDS

<table>
<thead>
<tr>
<th>Required by Government: -0-</th>
<th>Required by Host University: -0-</th>
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<tbody>
<tr>
<td><strong>Note:</strong> Students may be required to complete an ‘Intent to undergo a TB test’ form (see Appendix for sample) as part of the application process for a residence permit. Students are not required to get a TB test prior to arrival in the Netherlands, and U.S. citizens are generally not required to get a TB test at all. Some students may choose to get a TB test, but this is not a requirement and no physician signature is required.</td>
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</table>

### NEW ZEALAND

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<tr>
<th>Required by Government: -0-</th>
<th>Required by Host University: -0-</th>
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</table>

### RUSSIA

**Required by Government:**

To get a student visa for Russia, students must submit a negative HIV test result, taken within the previous 90 days. Results must contain the name, address and phone number of the hospital/laboratory/clinic where the test was taken. The document with the test result and their completed student visa application must be sent to Travisa by the student. Students have received instructions on how to proceed.

<table>
<thead>
<tr>
<th>Required by Host University: -0-</th>
<th>Required by UCEAP and the UCEAP Physician Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Successful completion of the UCEAP online Travel Health Course.</td>
<td></td>
</tr>
</tbody>
</table>

**IMPORTANT HEALTH ADVICE:** HIV/AIDS is prevalent and travelers are cautioned against unsafe sex, unsterile medical/dental facilities, shared needles, and unnecessary blood transfusions.
SENEGAL

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk, to be noted on the International Certificate of Vaccination (ICV). The certificate should be affixed to the visa inside of the student’s passport and presented at the port of entry.

Required by CIEE:
1. Malaria prophylactic pills—all students must sign a Malaria Prophylaxis Participation Agreement (see Appendix) and purchase antimalarials before leaving the U.S. (See Pg. 3 ‘UCEAP Student Insurance’ for coverage details that apply to antimalarial medication.)
2. Supplemental Medical Release for students with peanut allergy (see Appendix).

Required by UCEAP and the UCEAP Physician Consultant:
1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT HEALTH ADVICE:
- Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.
- Peanuts are the main crop of Senegal and are unavoidable. Most dishes contain them in some form, and everywhere the aroma of roasted peanuts permeates the air. Students whose allergies are severe enough to induce anaphylaxis should consider another program.

SINGAPORE

Required by Government:
1. YFI, if arriving from or transiting for more than 12 hours through countries with YF transmission risk.
2. The Medical Examination Report is required for students studying in Singapore for more than six months (i.e. academic year participants only). Students must use the official form identified by NUS. Instructions and a link to the form will be available in their NUS Registration Guide (see Appendix for sample form).
   - The Medical Examination Report is required by, and will be submitted to, the Singapore Immigration & Security Checkpoints Authority to issue certain immigration documents after arrival.
   - An HIV test and TB chest X-ray are required components of the medical examination. The original copies of the laboratory reports must be attached to the Medical Examination Report.
   - The Medical Examination Report should be completed in the U.S. no more than three months before the student’s NUS registration date in Singapore; otherwise, it will be considered invalid.
   - Waiting to complete the Medical Examination Report in Singapore could result in a delay with receiving the Student Pass required to participate in the program.

Required by Host University: -0-

IMPORTANT INFORMATION ABOUT THE PROGRAM:
- The NUS Biodiversity summer program includes a required weeklong field research trip to Pulau Tioman, a tropical island off the East coast of Malaysia.
SOUTH AFRICA

Required by Government for visa (do not submit to UCEAP):

1. Medical Certificate (form B1-811), one page (see Appendix).
2. Radiological Report (form B1-806), one page. Skin TB test is acceptable to attach in lieu of Radiological Report (chest X-ray). Either the results of a TB test or an X-ray report are required to submit to the consulate in order to obtain a student visa (see Appendix).
3. YFI, if arriving from or transiting through countries with YF transmission risk.

NOTE: Medical and TB test results (above) must not be older than 6 months at the time of visa application at the Los Angeles Consulate.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT HEALTH ADVICE:

- HIV is prevalent. Caution students about unsafe sex, unsterile medical or dental injections, shared needles, and unnecessary blood transfusions. Antiretroviral medications to prevent transmission of AIDS are readily available in South Africa if exposed to HIV-infected sources.
- The sun intensity is strong in South Africa; sun block is recommended throughout the year, even if traveling during their winter months. In summer, a hat and sunglasses are strongly recommended.

SPAIN

Required by Government for students who will be in Spain for more than six months: An original medical certificate meeting the following requirements:

- It must be printed on the medical facility’s letterhead.
- It must be signed by a physician (MD or DO). Stamped signatures are not acceptable.
- It must bear the official stamp of the administering medical facility in addition to the doctor’s signature.
- It must be issued in the place of the student’s residence.
- It must contain the required text in both English and Spanish, and each version must be signed and dated by the physician.

Required text:

<table>
<thead>
<tr>
<th>This medical certificate attests that Mr. / Ms. [student’s name as it appears on their passport] does not suffer from any illness that would pose a threat to public health according to the International Health Regulations of 2005.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>Este certificado médico acredita que el Sr./Srita [student’s name as it appears on their passport] no padece ninguna de las enfermedades que pueden tener repercusiones graves a la salud pública, en conformidad con lo dispuesto en el Reglamento Sanitario Internacional del 2005.</td>
</tr>
<tr>
<td>Firma</td>
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</tbody>
</table>

Continued on next page.
The doctor must certify that the student does not suffer from any illness that would pose a threat to public health according to WHO IHR 2005. This includes, but is not necessarily limited to: Smallpox, SARS, Human Influenza caused by a new subtype, Poliomyelitis due to wildtype poliovirus. Visit the World Health Organization website for additional information regarding the control and containment of known risks to public health.

- Any amendment to the certificate or erasure may render it invalid.
- The certificate is valid for three months from the issue date.

FYI: Students may be required to get a medical evaluation after arrival in Spain for visa renewal.

Required by Host University: -0-

SWEDEN

Required by Government: -0-  Required by Host University: -0-

SWITZERLAND

Required by Government: -0-  Required by Host University: -0-

TAIWAN

Required by Government: Year students ONLY will submit a supplemental health certificate (see Appendix) with their residence visa application. They are advised to do this after their arrival.

Required by Host University:

National Taiwan Normal University: -0-.

National Taiwan University – Visiting Students Health Exam Form, including chest X-ray results. Some lab tests on the form are optional. Refer to the notated sample form in the appendix.

Students have the option to upload the Visiting Students Health Exam Form to NTU as part of the online NTU application process or to submit the form upon arrival in Taiwan. In either case, the physical exam must be completed, and form signed by a healthcare professional, no more than three months prior to submission of the form to NTU. Physical exam timeframe guidelines:

- If student plans to submit the form as part of the online NTU application process:
  - the health exam must be done in January/February/March for Fall and Year programs
  - the health exam must be done in August/September/October for the Spring program

- If student plans to bring the form to Taiwan:
  - the health exam must be done in June/July/August for Fall and Year programs
  - the health exam must be done in December/January/February for the Spring program

Chest X-ray films do not need to be submitted to UCEAP or the host university.
TANZANIA

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by CIEE: Malaria prophylactic pills—all students must:

- sign a Malaria Prophylaxis Participation Agreement (see Appendix), and
- purchase antimalarials before leaving the U.S. (See Pg. 3 ‘UCEAP Student Insurance’ for coverage details that apply to antimalarial medication.)

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

THAILAND

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Recommended by Host University for students in the Public Health summer program:
Malaria prophylactic pills—it is recommended that students purchase antimalarials before leaving the U.S. (See Pg. 3 ‘UCEAP Student Insurance’ for coverage details that apply to antimalarial medication.)

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT HEALTH ADVICE:

- Help students to understand that they must protect themselves from malaria by taking antimalarials and precautions to prevent mosquito bites.
- Bangkok has poor air quality, had the worse dengue epidemic in 20 years in 2013, and has a high incidence of rabies. Advise accordingly.
- Warn students to avoid places such as poultry farms and bird markets where live poultry is raised or kept, and avoid contact with sick or dead poultry.
- Thailand now has the highest number of officially reported AIDS cases in Southeast Asia. Talk to students about unsafe sex, unsterile medical/dental facilities, shared needles, and unnecessary blood transfusions.
- Students with severe food allergies should be advised to take precautions, as the cuisine commonly includes ingredients that can cause anaphylaxis in those affected.

IMPORTANT INFORMATION ABOUT THE PROGRAM:

- The summer programs include required fieldtrips to other regions of Thailand.

TURKEY

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.
UNITED KINGDOM

Required by Government: -0-  Required by Host University: -0-

Note: Group C meningococcal vaccination may be required after arrival by some host universities.

VIETNAM

Required by Government: YFI, if arriving from or transiting through countries with YF transmission risk.

Required by Host University: -0-

Required by UCEAP and the UCEAP Physician Consultant:

1. Successful completion of the UCEAP online Travel Health Course.

IMPORTANT INFORMATION ABOUT THE PROGRAM:

• Can Tho is located in the Mekong Delta in southwestern Vietnam. Vietnam’s delta areas are highly prone to flooding, which gets worse during the wet season (July-November). Risks include:
  o Mosquito-borne illnesses, particularly Dengue Fever
  o Groundwater contamination

• The Mekong Delta has an agriculturally-based economy and culture. Student access to western comforts will be limited, and the risk of culture shock may be greater.

• The program includes required weekly field research trips in the Can Tho area, and two major field research trips to other regions of Vietnam.

• Students must be prepared mentally and physically for the program and the research field trips.

IMPORTANT HEALTH ADVICE:

• Advise students to avoid places such as poultry farms and bird markets, where live poultry are raised or kept, and avoid contact with sick or dead poultry.

• No psychological services available in English (as of May 10, 2013) in Can Tho. The nearest resources identified are in Ho Chi Minh, which is a three-hour drive.

• Students with severe food allergies should be advised to take precautions, as the cuisine commonly includes ingredients that can cause anaphylaxis in those affected. Additionally, students will be in areas where medical care is significantly limited.
APPENDIX

SAMPLE UCEAP FORMS

Annual UCEAP Health Update 2015-2016
UCEAP Health Clearance Instructions

You are required to obtain a health clearance to participate in UCEAP. If you do not comply, you may be dismissed. UCEAP and the UC campus reserve the right to require a health clearance through the campus Student Health Service. Follow your campus Student Health Service procedures to acquire a health clearance through them. DO NOT DELAY. You are responsible for meeting all deadlines. The health clearance must be completed no later than two months (60 days) before departure*.

<table>
<thead>
<tr>
<th>HEALTH CLEARANCE REQUIRED FROM CAMPUS STUDENT HEALTH SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana                      Ghana                       India</td>
</tr>
<tr>
<td>Senegal                      South Africa                 Tanzania</td>
</tr>
<tr>
<td><strong>INSTRUCTIONS:</strong></td>
</tr>
<tr>
<td>The campus Student Health Service (SHS) must clear you following campus protocols. Some limit the number of ‘Health Clearance’ appointments that are offered. Others have deadlines for submitting your Confidential Health History form. Begin this process early.</td>
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</table>

<table>
<thead>
<tr>
<th>HEALTH CLEARANCE REQUIRED FROM CAMPUS SHS – OR – PRIVATE PHYSICIAN</th>
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</thead>
<tbody>
<tr>
<td>Argentina                      Australia                    Barbados</td>
</tr>
<tr>
<td>Brazil                           Canada                        Chile</td>
</tr>
<tr>
<td>China                           Costa Rica                    Dominican Republic</td>
</tr>
<tr>
<td>Czech Republic                   Denmark                       France</td>
</tr>
<tr>
<td>Germany                       Hong Kong                    Indonesia</td>
</tr>
<tr>
<td>Russia                        Singapore                    Switzerland</td>
</tr>
<tr>
<td>South Africa                   Tanzania                      Thailand</td>
</tr>
<tr>
<td><strong>INSTRUCTIONS:</strong></td>
</tr>
<tr>
<td>Obtain a health clearance either from the campus Student Health Service (SHS) or from a private physician, according to campus-specific protocols. For a campus SHS health clearance follow all instructions provided by the campus EAP or SHS office. UCEAP and/or the campus reserve the right to require the clearance through the campus Student Health Service. If you decide to use a private physician, instructions are on the following page.</td>
</tr>
</tbody>
</table>

Complete the process by stipulated deadlines, but no later than two months (60 days) before departure*.

* Except Chile: If you will apply for the visa at Los Angeles Consulate of Chile, you must submit a health clearance that is dated 30 days, or less, before the application date of your visa. The Consulate of Chile located in San Francisco does not have this requirement.

<table>
<thead>
<tr>
<th>ONLINE TRAVEL HEALTH COURSE</th>
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<tbody>
<tr>
<td>Argentina                     Barbados                   Botswana</td>
</tr>
<tr>
<td>Brazil                        China                        Costa Rica</td>
</tr>
<tr>
<td>Dominican Rep.                Ghana                       India</td>
</tr>
<tr>
<td>Indonesia                     Multi-city Programs that include any of the above countries</td>
</tr>
<tr>
<td>Jordan                        Mexico                      Morocco</td>
</tr>
<tr>
<td>Russia                        Senegal                     South Africa</td>
</tr>
<tr>
<td>Tanzania                      Thailand                    Turkey</td>
</tr>
<tr>
<td>Vietnam</td>
</tr>
</tbody>
</table>

This course does not replace an in-person appointment with a travel health specialist for necessary travel medications and immunizations.

**INSTRUCTIONS:**
Complete the online UCEAP Travel Health Course according to instructions in the Pre-Departure Checklist for your program. The online travel health course teaches you about:

- vaccine-preventable diseases,
- personal protective measures against insect bites,
- food and water safety,
- travel with medication,
- personal safety precautions, etc.

After you complete the course, make an appointment with a travel health specialist at the campus SHS—or a private travel health specialist. Only medical professionals can provide advice about vaccinations and medications.
HEALTH CLEARANCE THROUGH A PRIVATE PHYSICIAN

1. Pick up a blank Confidential Health History form from your campus EAP advisor or SHS –OR– access it online, according to campus protocols. You must
   a. complete the form clearly and accurately before seeing a doctor, and
   b. SIGN it (if paper version) or SUBMIT it (if electronic version).

2. Pick up a blank UCEAP Health Clearance form from your campus EAP advisor or SHS –OR– access it online, according to campus protocols. You must
   a. follow detailed campus instructions, and
   b. ensure the form includes your name and complete program information (Country, Host Univ, and Term)

3. Make appointments with your personal doctor and specialist(s) only if your UCEAP destination and campus allow clearances from outside practitioners. Specialist clearances should be done BEFORE to the General Practitioner clearance. You must
   a. take the completed Confidential Health History and UCEAP Health Clearance forms to each appointment.
   b. ask the physician to follow the instructions on the UCEAP Health Clearance form carefully.

AFTER THE HEALTH CLEARANCE IS COMPLETED AND SIGNED

1. UCEAP Health Clearance – You are responsible to mail the original and 1 copy of the completed form to:
   University of California, Education Abroad Program, Systemwide Office
   6950 Hollister Avenue, Suite 200, Goleta, CA 93117-5823

   UCEAP must receive this form at least two months before departure to prevent delays in participation*.  

   * Except Chile: The Consulate of Chile in Los Angeles requires that clearances be completed and dated 30 days, or less, before your visa application date. The Consulate in San Francisco does not have this requirement.

2. Confidential Health History
   a. Leave a copy of the completed Confidential Health History form with your doctor for your file.
   b. Take a copy with you when you travel in case of an emergency.
   c. Do not send a copy to the UCEAP Systemwide Office.

STUDENTS WITH SPECIAL NEEDS: Students who have any disability, or other chronic systemic condition for which they will seek accommodation abroad are advised to alert the Campus EAP office immediately so staff can notify the UCEAP Systemwide Office. The UC campus Disabled Students Office must send a memo to UCEAP indicating the nature of the student’s needs. In light of varying conditions and services available, universities abroad may require this memo with sufficient notice for a request for accommodations to be fairly evaluated. The students must secure funding for the accommodation. Students who disclose needs at the last minute, or who require accommodations that cannot be made available in the host country, may be advised to postpone participation or consider another site. (NH 12/2013)
Confidential Health History Form

*** DO NOT SEND A COPY OF THIS FORM TO YOUR CAMPUS EAP OFFICE OR TO THE UCEAP SYSTEMWIDE OFFICE ***

Instructions for Students
(Read carefully and complete attached before the health clearance)

• The UCEAP Health Clearance is a requirement to participate in UCEAP. IT CANNOT BE WAIVED. If you do not comply with all aspects of the UCEAP health clearance process, you may be dismissed from UCEAP.

• Complete this form accurately and truthfully before the health clearance consultation. Failure to provide complete and accurate information may be grounds for non-participation in UCEAP.

• Inform UCEAP of any recent medical or special needs and/or if any changes in health occur after the health clearance. You will be required to get a second clearance should your health history change since the date of the initial clearance.

• Disclose on this form all medical history to the health provider performing your clearance; even if you believe that a condition is under control. Your confidential disclosure will allow medical professionals to help you make arrangements or plans to facilitate your successful UCEAP experience. Identifying medical or mental health problems allows everyone involved in this process the opportunity to work with you to anticipate potential complications. We strongly encourage you to disclose so you can have a meaningful, rewarding and safe experience.

If you have a chronic medical condition, such as allergies or diabetes, prepare to manage your condition abroad. Consider how the new environment and the stresses of study abroad will affect your health. Preexisting psychological conditions are often intensified by living in a different culture. Also, there may be fewer, or inadequate, local resources to help you manage potential triggers.

For Students Traveling with Medication

1. Make sure that it is legal abroad and that you can take a supply to last throughout your stay. Medications that are legal and commonly prescribed in the U.S. may be considered illegal, require a prescription, or a host country authorization to be allowed in the country. Host-country national laws mandate what can be brought into a country. Every country has a different classification system for medicines. Although medications in amounts clearly related to personal use are rarely inspected or questioned, customs officials can become suspicious of medications in large quantities. If intending to travel with a controlled drug for personal use, it is prudent to review medication regulations in official government sites. Addresses and excerpted national statutes for most countries can be found at the International Narcotics Control Board, www.incb.org/incb/en/psychotropic-substances/travellers_country_regulations.html. Refer to #5 below, Mailing Medications.

2. Carry a letter from your physician, on letterhead, explaining your diagnosis, treatment, and list of prescribed medications. When going through Customs abroad, officials may scrutinize medications. Carry your prescription in original containers, and keep the letter from your physician handy.

3. If you are taking a psychotropic, you must be stable on your medication. Medically stable means that you must be in a state where any changes in symptoms are not foreseen or expected. Discuss proper medication management with your doctor before departure.

4. If you are being treated for a psychological condition, work closely with your doctor to design a treatment plan and understand possible triggers, what medications you are taking, if they are available overseas, and how to reach out for help while abroad, if needed.

5. Mailing medications abroad: Individuals cannot mail medications abroad. Medications can only be mailed by registered practitioners or dispensers. Most countries have strict regulations on shipping medication abroad. Decisions on what medications are accepted into the country are made by the host country government; not the U.S. Post Office. Medications can be stopped by the host country’s Customs that will require payment of fees, completion of documentation, and several trips to the Customs office.

Instructions (depending on the campus)

☐ FILL OUT the confidential form completely and honestly before your health appointment.

☐ TAKE the completed form with you to your appointment and discuss your health history with the health practitioner.

☐ GIVE a copy of this form to the health care professional who performed your clearance.

☐ TAKE a copy abroad in case of a medical emergency. Do not mail a copy to the UCEAP Systemwide Office.
UCEAP Confidential Health History Form

*** DO NOT SEND THIS CONFIDENTIAL FORM TO UCEAP ***

The UCEAP health clearance must be completed 60 days before departure (except for Chile). It is a non-waivable requirement. IF YOU ARE NOT IN COMPLIANCE, YOU MAY NOT BE APPROVED TO PARTICIPATE IN, OR MAY BE DISMISSED FROM UCEAP.
Your answers below and a review of your medical & mental health records on file will be used during the health clearance process.
You must inform UCEAP 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 could prevent complications during an emergency and/or help to plan better for a successful and safe experience abroad.

PRINT:
Last name ___________________ First ___________________ Middle _______ Sex: M ☐ F ☐
Program/Country ___________________ Student I.D. ___________________

Person to notify in case of emergency:
NAME ___________________
ADDRESS: STREET ___________________ CITY ___________________ STATE, ZIP CODE ___________________
DAYTIME PHONE, INCLUDE AREA CODE ___________________

GENERAL HEALTH:
List any recent or continuing health problems: __________________________________________________________
List any physical or learning disabilities: _______________________________________________________________
Are you currently (last 12 months) 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: ______________________________

MEDICAL HISTORY: Students with known and ongoing medical conditions must prepare for and manage their condition overseas. Complete below:

<table>
<thead>
<tr>
<th>chronic headaches/migraines</th>
<th>Ulcer/collitis</th>
<th>Back/joint problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy/seizures</td>
<td>Hepatitis/gallbladder</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Asthma/lung disease</td>
<td>Bladder/kidney problems</td>
<td>Thyroid problems</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Diabetes</td>
<td>Recurrent or chronic infectious diseases</td>
</tr>
<tr>
<td>Anemia or bleeding disorder</td>
<td>Cancer/tumors</td>
<td>Other (List)</td>
</tr>
</tbody>
</table>

MENTAL HEALTH HISTORY: Have you ever been diagnosed, been treated for, or hospitalized for the following?

<table>
<thead>
<tr>
<th>any mental health condition, including depression/anxiety</th>
<th>substance abuse (alcohol or drugs)</th>
<th>eating disorder (anorexia/bulimia)</th>
</tr>
</thead>
</table>

IMMUNIZATION RECORD: Indicate most recent date.

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio immunization</td>
<td>Measles</td>
<td>Mumps</td>
</tr>
<tr>
<td>Tetanus booster or Tetanus/diphtheria booster</td>
<td>Rubella</td>
<td>MMR</td>
</tr>
</tbody>
</table>

MEDICATIONS: Student is responsible for ensuring that all medications are legally permissible abroad.

Are you currently taking any medications? Y ☐ N ☐ Specify name, type, & brand of any medication and whether you use inhaler, bee sting kit.

SERVICES YOU WILL NEED TO FACILITATE YOUR EDUCATION (e.g., note takers)

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: ___________________

One copy: Student (keep with passport in case of a medical emergency). One copy: Health provider. ** DO NOT SEND A COPY TO UCEAP **
Student may make additional copies for health care provider and Study Center Office abroad.
EAP Health Clearance Form

REQUIREMENTS

- Health care providers must be licensed and cannot be an immediate family member. AMA Code of Ethics E-8.19
- Health care providers must provide legible contact information.
- The student’s name and program information must appear on the form. Blank forms are not acceptable.
- The University of California may not approve a student’s participation in UCEAP unless a licensed health care provider certifies that the student is medically stable.
- The student must be assessed to participate in UCEAP by a health care provider and a specialist if the student is currently being treated by one.
- The student may be required to get a second clearance should there be a change in health history since the date of the initial clearance.

STUDENT INSTRUCTIONS – Also refer to your UC campus health clearance instructions.

This is a mandatory requirement. Your information is confidential and only shared on a need to know basis to facilitate assistance, particularly during an emergency. Deadline: No later than 60 days before departure (except for Chile).

1. Do not delay in making your health clearance appointment. Some campuses have limited appointments. If you do not comply with this requirement, you may not be approved to participate in, or may be dismissed from UCEAP. Even if your program allows a health clearance through a private physician, UCEAP and/or the campus EAP Office reserve the right to require a clearance through the campus Student Health Center.

2. Complete the Confidential Health History form (if your campus has online clearance procedures, follow them).

3. Legibly write your name, UC campus, and UCEAP program name (country, host institution, and term), on the attached form before your appointment.

4. Inform the UCEAP Systemwide Office (UCEAP) of medical needs, accommodations, and/or changes in health that occur after the health clearance process. Failure to provide complete and accurate information may be grounds for non-participation in, or dismissal from, UCEAP.

5. After your appointment, return the completed and signed original and a copy by the stipulated deadline to:
   UCEAP Systemwide Office, University of California, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117-5823

HEALTH CARE PROVIDER INSTRUCTIONS

1. The student must present to you a completed UCEAP Confidential Health History form. A physical examination is not needed unless required by the program or UC Student Health Center.

2. Discuss/review the student’s health history referring to the Confidential Health History form completed by the student and the student’s medical records on file.

3. Focus on any condition requiring medication and/or continued treatment while abroad.
   a. Students may be cleared for participation if:
      i. in the opinion of the examining health care provider and/or specialist any medical condition is under control,
      ii. they have a contracted treatment plan in place (if there is any evidence of recent physical/mental health treatment), for required and recommended care while abroad, and
      iii. they have been stable on their medication for a reasonable period.

4. Advise student to find out if their medication is locally available or if there is an appropriate substitute.
University of California UCEAP Health Clearance Form

STUDENT: Print clearly with a ball point pen before appointment.

First and Last Name of Student ____________________________  UC Campus ____________________________  UCEAP Program Name ____________________________  (Country ____________________________  Host University ____________________________  Term ____________________________

HEALTH CARE PROVIDER must be licensed to practice and cannot be an immediate family member (AMA Code of Ethics E-8.19). Only disclose information that is necessary and relevant to UCEAP’s duties.

I have reviewed the student’s Confidential Health History form and medical records on file. Based on the information provided to me by the student on the form, a review of the student’s personal health history, and knowing the student’s UCEAP country destination, to the best of my knowledge, the student is:

Licensed Psychotherapist or Licensed Specialist (Section & signature required if student is being treated by one.)

1.  ☐ CLEARED (Check all that apply below)
   ☐ 1.a No medical or psychiatric contraindications to UCEAP participation.
   ☐ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.

   ☐ 1.c Student advised to arrange 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.d Student advised to find out if medication (or appropriate substitute) is locally available. If not locally available, student advised to carry a sufficient supply to last through entire program (if allowed by customs). If on medication, please list.

   ☐ 1.e List significant allergies (e.g., medication, food, etc.):

2.  ☐ NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Psychotherapist –or– Licensed Specialist (PRINT LEGIBLY name and title) ____________________________  Phone number (include area code) ____________________________

Signature: __________________________________________________________________________

Date: ____________________________

Licensed Physician or Health Care Provider (MD, DO, NP, RN, or PA)

1.  ☐ CLEARED (Check all that apply below)
   ☐ 1.a No medical or psychiatric contraindications to UCEAP participation.
   ☐ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC Disability Services Office documenting the disability and indicating who will pay for services is required.

   ☐ 1.c Student advised to arrange 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.d Student advised to find out if medication (or appropriate substitute) is locally available. If not locally available, student advised to carry a sufficient supply to last through entire program (if allowed by customs). If on medication, please list.

   ☐ 1.e List significant allergies (e.g., medication, food, etc.):

2.  ☐ NOT CLEARED: There are medical or psychiatric contraindications to UCEAP participation.

Licensed Physician/Health Provider: MD, DO, NP, RN, or PA (PRINT LEGIBLY name and title) ____________________________  Phone number (include area code) ____________________________

Signature: __________________________________________________________________________

Date: ____________________________

Upon completion, the student must send the original and one copy of this form to UCEAP by the deadline. UCEAP will mail one copy to the UCEAP Study Center.
UCEAP LIMITED AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

INSTRUCTIONS:

1. Complete all BLANK sections. SIGN and DATE the form.

2. PROVIDE A COPY of this limited authorization to each physician, health practitioner, or psychotherapist, who has seen you in the past 12 months.

3. RETURN COMPLETED, SIGNED, form to: Ines DeRomana, Health, Safety and Emergency Response, University of California System, Education Abroad Program, (UCEAP), 6950 Hollister Avenue, Suite 200, Goleta, CA 93117. Email, ideromana@eap.ucop.edu.

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide all information requested may invalidate this Authorization.

Use and Disclosure of Health Information

I, ________________________________________________, ("Student"), participating in PRINT student's name

UCEAP Program Name include, Country, Host University and Term

hereby authorize all physicians, all health practitioners, and all psychotherapists, who have provided care to me within the last twelve (12) months, including each person listed on the last page of this limited authorization to release to University of California Education Abroad Program Universitywide Office, c/o Inés DeRomana

the following information:

a. ☒ All health information pertaining to my medical history, mental or physical condition and treatment received — OR

   ☐ Only the following records or types of health information (including any dates):

b. I specifically authorize release of the following information (check as appropriate):

   ☒ Mental health treatment information

   ☐ HIV test results

   ☒ Alcohol/drug treatment information

1 If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.
A separate authorization is required to authorize the disclosure or use of psychotherapy notes as defined by HIPAA (45 C.F.R. section 164.501). Further, I authorize the University of California, Education Abroad Program (UCEAP) and its agents to contact my emergency contact as indicated on the emergency form, in connection with my general welfare abroad.

**Purpose**

Purpose of requested use or disclosure:  

☐ patient request  

OR  

☐ other: To obtain an UCEAP health clearance, to obtain information regarding Student’s compliance with any conditional health clearance provisions during UCEAP, for use in seeking health care for Student while abroad as part of UCEAP, and to notify the emergency contact on record at UCEAP of any health emergency Student suffers while participating in the UCEAP program

**Expiration**

This Limited Authorization expires upon completion of Student’s participation in UCEAP.

**My Rights**

I may refuse to sign this Limited Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. However, this Limited Authorization must be signed to obtain a health clearance to participate in UCEAP.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this Limited Authorization at any time, but I must do so in writing and submit it to the following address: Inés DeRomaña, University of California Education Abroad Program Systemwide Office, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Limited Authorization.

I have a right to receive a copy of this Limited Authorization.

Information disclosed pursuant to this Limited Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

A scanned copy attached to an email message, a facsimile, or a photocopy of this signed and completed Limited Authorization may be used as if it is a signed and completed original.

**Student’s Signature**

Date: ______________________  

Time: __________________ am/pm

Signature: ____________________________________________________________

(patient/representative/spouse/financially responsible party)

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2 If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan’s eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(d)(1), (e)(2)).
LIST OF HEALTH PROVIDERS

List each physician, each health practitioner, and each psychotherapist, who has provided care to Student within the last twelve (12) months:

Please print.

☐ UC Student Health Service
☐ UC Student Counseling Center

Name ________________________________________________________________
Address _____________________________________________________________
Telephone ________________________________

Name ________________________________________________________________
Address _____________________________________________________________
Telephone ________________________________

Name ________________________________________________________________
Address _____________________________________________________________
Telephone ________________________________

Name ________________________________________________________________
Address _____________________________________________________________
Telephone ________________________________
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AS OF THE PRINTING OF THIS REPORT, THE CONTRACT TO PROVIDE TRAVEL INSURANCE FOR UCEAP PARTICIPANTS IN 2015-16 PROGRAMS HAS NOT BEEN FINALIZED.

Once finalized, the electronic version of the 'Benefits at a Glance' document will be posted here: http://www.eap.ucop.edu/Documents/Insurance/1516/2015-16_UCEAP_Insurance_Benefits_at_a_Glance.pdf
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APPENDIX
SAMPLE COUNTRY-SPECIFIC FORMS

Annual UCEAP Health Update 2015-2016
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MEDICAL QUESTIONNAIRE TO BE COMPLETED PRIOR TO ACCEPTANCE FOR ADMISSION TO THE UNIVERSITY OF THE WEST INDIES (CAVE HILL CAMPUS)

Part A is to be completed and signed by the applicant.

Part B is to be completed by a Registered Medical Practitioner who has examined the applicant.

Both parts must be completed by writing “Yes” or “No” in the proper space. If “Yes” is answered, the details relevant to the question must be inserted.

Positive answers do not necessarily imply the refusal of the applicant. Answers given to the questions will be of assistance to the student in his/her University career.

**PART A**

<table>
<thead>
<tr>
<th>Applicant’s Last Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name(s):</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td>_________________</td>
</tr>
</tbody>
</table>

Name of Parent/Guardian/Next of Kin: ____________________________________________

<table>
<thead>
<tr>
<th>1. Have you ever had:</th>
<th>No</th>
<th>Yes</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2. Is there any physical or mental disorder for which you may need special attention or supervision during your studies? | | |
|-------------------------------------------------------------------------------------------------------------|---|---|---|

**SIGNED:** ______________________________

**DATE:** ______________________________
PART B

TO BE COMPLETED BY THE PHYSICIAN AFTER PART A
HAS BEEN COMPLETED BY APPLICANT

Please note below any conditions you consider significant. If there is any other information of which we should be aware please submit separately under confidential cover.

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes</td>
<td>Is there any abnormality on general physical examination including urine test?</td>
</tr>
<tr>
<td>2.</td>
<td>*Yes</td>
<td>Is there any physical or mental disability which might handicap the candidate in his/her studies?</td>
</tr>
<tr>
<td>3.</td>
<td>Yes</td>
<td>Is there any evidence of recent infectious disease?</td>
</tr>
<tr>
<td>4.</td>
<td>Yes</td>
<td>Is there any history of allergies or adverse drug reactions?</td>
</tr>
</tbody>
</table>
| 5. | Yes | Has the candidate been treated for any of the following:  
- Asthma  
- Epilepsy  
- Hypertension  
- Diabetes |
| 6. | **Yes | Is the candidate immunized against:  
- Tetanus  
- Diphtheria  
- Anterior Poliomyelitis  
- B.C.G.  
- Rubella  
- Hepatitis B |

*If YES, please forward, thorough patient medical details under confidential cover, to Doctor, Student Health Service, The University of the West Indies, Cave Hill Campus

**Patient is required to submit documented details

SIGNED: ________________________________

FULL NAME: ________________________________

ADDRESS: ____________________________________________

__________________________________________

__________________________________________

DATE: ________________________________
MALARIA PROPHYLAXIS
PARTICIPATION AGREEMENT

I (Print Student Name) understand that malaria is present in various parts of Botswana year-round, including in urban areas, though not in Gaborone. I understand that travelers to sub-Saharan Africa have the greatest risk of both getting malaria and dying from their infection. I understand that transmission is generally higher in Africa south of the Sahara than in most other areas of the world.

I understand that most residents of the United States have never developed resistance (immunity) to the disease and that malaria infection in a non-immune person can quickly result in a severe and life-threatening illness.

I agree to consult with my UC campus Student Health Services physician before my participation in the Education Abroad Program in Botswana regarding the anti-malaria prophylaxis treatment most appropriate and learn about personal protective measures.

I agree to continue the prescribed malaria prophylaxis regime if I plan to leave the urban Gaborone area and that missed or delayed doses may increase the risk of getting malaria.

I understand that anti-malarials are not 100% effective so insect protection measures are essential in addition to any prophylactic regimen. I agree that I will follow personal protection measures (i.e. wear appropriate clothing, use permethrin-treated bed nets, use of aerosol insecticides, vaporizing mats and mosquito coils, etc.)

As a voluntary participant in the Education Abroad Program in Botswana, I will follow the doctor’s recommended malaria prophylaxis as prescribed and I certify that I have read and understood the above. I understand that failure to comply with these requirements could result in my dismissal from the program.

Signature of Student ______________________________________________________

UC Campus ________ Date ____________________________

Updated January 2012
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Sample Chinese health form for students that will be studying in China for more than six months (ex. BNU Summer+Fall, Peking University Year) and will apply for a residence permit after arrival.

> 6 month residency - China

**PHYSICAL EXAMINATION RECORD FOR FOREIGNER**

<table>
<thead>
<tr>
<th>Name</th>
<th>Last, First</th>
<th>Sex</th>
<th>Female</th>
<th>Date of birth</th>
<th>Blood Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizenship</td>
<td>Must match passport.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present mailing address</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth address</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State and country</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Past Medical History:**

Have you ever had any of the following diseases? (Each item must be answered “Yes” or “No”)

- Typhus fever
- Poliomyelitis
- Diphtheria
- Scarlet fever
- Relapsing fever
- Bacillary dysentery
- Brucellosis
- Viral hepatitis
- Puerperal streptococcus infection
- Typhoid and paratyphoid fever
- Epidemic cerebrospinal meningitis

**Past Criminal History:**

Do you have any of the following diseases or disorders endangering the Public order and security? (Each item must be answered “Yes” or “No”)

- Toxicomania
- Mental confusion
- Manic psychosis
- Paranoid psychosis
- Hallucinatory psychosis

The remainder of the form must be completed in full by the physician. Please note metric measurement units.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood pressure</th>
<th>mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm</td>
<td>kg</td>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Eye</td>
<td>Skin</td>
<td>Lymph nodes</td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td>Lungs</td>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Tonsils</td>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>脊柱</td>
<td>四肢</td>
<td>神经系统</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Spine</td>
<td>Extremities</td>
<td>Nervous system</td>
<td></td>
</tr>
</tbody>
</table>

**其它所见**
Other abnormal findings

**Physician must indicate something in each box, even if it is "none found."**

- Attach original X-ray report, not films. Photocopies are not accepted.
- Attach original ECG printout.

**化验室检查**
Laboratory exam.

- HIV, Syphilis serodiagnosis

Must state clearly:
- AIDS – negative or positive
- Syphilis – negative or positive

- The original HIV test must be attached, photocopies are not accepted.

**未发现患有下列检疫传染病和危害公共健康的疾病：**
None of the following diseases or disorders found during the present examination:

- Cholera
- Yellow fever
- Plague
- Leprosy
- Venereal disease
- Opening lung tuberculosis
- AIDS
- Psychosis

**意见**
Suggestion

- If any.

**检查单位盖章**
Official stamp

- Official stamp of clinic, hospital, or physician. An address stamp is acceptable.

**Physician that completed the exam signs and dates the form.**

**医师签字**
Signature of physician

**日期**
Date YYYYY-MM-DD
MALARIA PROPHYLAXIS
PARTICIPATION AGREEMENT

I (Print Student Name)________________________________________________________
understand that malaria is present throughout Ghana year-round, including in urban areas. I understand that travelers to sub-Saharan Africa have the greatest risk of both getting malaria and dying from their infection. I understand that transmission is generally higher in Africa south of the Sahara than in most other areas of the world.

I understand that most residents of the United States have never developed resistance (immunity) to the disease and that malaria infection in a non-immune person can quickly result in a severe and life-threatening illness.

I agree to consult with my UC campus Student Health Services physician before my participation in the Education Abroad Program in Ghana regarding the anti-malaria prophylaxis treatment most appropriate and learn about personal protective measures.

I agree to continue the prescribed malaria prophylaxis regime through my stay in Ghana and that missed or delayed doses may increase the risk of getting malaria.

I understand that such malaria prophylaxis is required by the regulations of the University of Ghana.

I understand that anti-malarials are not 100% effective so insect protection measures are essential in addition to any prophylactic regimen. I agree that I will follow personal protection measures (i.e. wear appropriate clothing, use permethrin-treated bed nets, use of aerosol insecticides, vaporizing mats and mosquito coils, etc.)

As a voluntary participant in the Education Abroad Program at the University of Ghana, I will follow the doctor’s recommended malaria prophylaxis as prescribed and I certify that I have read and understood the above. I understand that failure to comply with these requirements could result in my dismissal from the program.

Signature of Student __________________________________________________________

_________________________________________   _________________
UC Campus   Date

Updated January 2012
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HEALTH HISTORY FORM

Name: (Surname, Other names) (Chinese)

Sex: M/ F Date of Birth: Place of Birth: Marital Status: Single/ Married
Home Address: Phone: Home:

Mobile:

Correspondence Address (if different): Nationality:

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name: Relationship: Phone:
Address:

FAMILY HISTORY:

<table>
<thead>
<tr>
<th>Relation</th>
<th>Sex/Age</th>
<th>Occupation</th>
<th>State of Health</th>
<th>Cancer</th>
<th>Heart Disease</th>
<th>Hypertension</th>
<th>Diabetes</th>
<th>Hypercholesterolemia</th>
<th>Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers &amp; Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

HEALTH PROBLEMS:

Have you ever had the followings?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic Rhinitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema/Dermatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcer Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please specify (Date; Duration; Treatment & Follow-up):

LONG TERM MEDICATIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage &amp; Frequency</th>
<th>Date started (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you ALLERGIC to any food/ medications? Yes □ No □ If Yes, please specify?

MENSTRUAL HISTORY (For female students only)

Age of first menstruation: Days

Month of first period:

Number of days of menses:

Quantity of menses:

Menstrual Pain:

Other:

41
Do you smoke? Yes □ No □ If yes, please specify how many? ______ pack/day _______ years

Do you drink alcohol? Yes □ No □ If yes, please specify how much? _______ drinks/week

In the past 3 months, did you have:

(i) Cough for more than 4 weeks?
(ii) Cough with blood stained sputum?
(iii) Unexplained low grade fever?
(iv) History of contact with T.B. patients?

Do you frequently have insomnia, feel anxious or emotional upset?

Do you need counseling or like to discuss confidentially with the health staff for your personal, health, social or emotional problem?

Do you have any physical handicap which may require special provisions to adjust to university life?

Do you have amblyopia?

Are you troubled by any defect in speech?

Do you have any impairment of hearing?

IMMUNIZATION

<table>
<thead>
<tr>
<th>Disease</th>
<th>First Dose</th>
<th>Second Dose</th>
<th>Third dose</th>
<th>First Dose</th>
<th>Second Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td>__________</td>
<td>Measles, Mumps, Rubella</td>
<td></td>
</tr>
<tr>
<td>(甲型肝炎)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td>BCG</td>
<td></td>
</tr>
<tr>
<td>(乙型肝炎)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twinrix</td>
<td></td>
<td></td>
<td></td>
<td>Chickenpox</td>
<td></td>
</tr>
<tr>
<td>(甲乙型肝炎)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td></td>
<td></td>
<td></td>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>(小兒麻痹)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT (Triple Vaccine)</td>
<td></td>
<td></td>
<td></td>
<td>HPV Vaccine</td>
<td></td>
</tr>
<tr>
<td>(白喉,破傷風,百日咳)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphtheria-Tetanus</td>
<td></td>
<td></td>
<td></td>
<td>Other Vaccines</td>
<td></td>
</tr>
<tr>
<td>(白喉,破傷風)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus Toxoid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(破傷風類毒素)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: ___________________  Student Signature: ______________________

For Official Use

Body Weight (kg) __________
Height (m) __________
BMI __________
Blood Pressure __________/__________
Remarks ______________________

RETURN COMPLETED FORM TO:
The Director
University Health Service
The Chinese University of Hong Kong
Shatin, N.T.

August 2008
Report of Medical Examination

Please keep in mind that we do not accept forms completed by a relative. Incomplete forms will not be accepted.

The applicant should complete this section.

PLEASE TYPE OR PRINT CLEARLY AND BRING A COPY OF THIS FORM WITH YOU TO JERUSALEM.

Name of Applicant_________________________________________Social Security Number_____

Please indicate the program to which you are applying_____

Address_________________________________________________________________________

E-mail Address ________________________________________________________________

The physician should complete the remainder of this report of medical examination.

To the examining physician - Your health evaluation is an essential part of the application for participation in study abroad programs at the Hebrew University. We require a full physical examination. Please include results of your lab work on this report; do not submit lab reports with this evaluation.

Date of Birth_________________________Age_________________________Gender ________________

Past or present illnesses (Please give dates, complications, and any residual symptoms):

A. History of heart disease (valve disorders, congenital malfunctions, etc.) ______________________

B. Rheumatic fever (heart involvement) ______________________________________________________

C. Diseases of the digestive tract: (peptic ulcer; biliary tract disease, chronic or recurrent diarrhea, severe constipation, vomiting spells, hernia, appendicitis) ____________________________

D. Respiratory diseases (tuberculosis, asthma, chronic bronchitis, bronchiectasis, sinus disease) _________

E. Urinary tract diseases (nephritis, nephrosis, calculi, recurrent bladder or prostatic disease, history of urinary tract infection) _________________________________

F. Disorders of menstruation (give details) ______________________________________________________

G. Diabetes mellitus ____________________________________________________________

H. Hypertension _________________________________________________________________________

I. Migraine or severe headaches (dizzy spells, strokes) _________________________________

J. Epilepsy, fainting spells, history of head injuries __________________________________________

K. Muscle disease ______________________________________________________________________

L. Allergic diseases (hay fever, food allergies). Please record causative factors ______________________

M. Chronic skin diseases ____________________________

N. Severe injuries _______________________________________________________________________

O. Surgeries (list surgeries and dates. If none, write "none") ________________________________

P. Systemic disease (juvenile rheumatoid arthritis, lupus, erythematosis) ________________________________

43
Report of Medical Examination, continued

Name of Applicant ___________________________ Social Security Number ___________________________

Please conduct a complete examination: Height ___________ Weight ________________

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Deviation from Normal</th>
<th></th>
<th>Normal</th>
<th>Deviation from Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
<td>Tonsils</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td>Feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
<td></td>
<td>Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth</td>
<td></td>
<td></td>
<td>Blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td>Urinalysis</td>
<td></td>
<td>(dipstick &amp; microscopic, if indicated)</td>
</tr>
</tbody>
</table>

1. List special dietary requirements (i.e., low sodium) ____________________________________________

2. If the applicant is receiving any medication, please attach statement of such medication with dosage and instructions to keep on file.

3. Bearing in mind the various conditions imposed by a foreign study program (lengthy absence from home, adjustment to a foreign culture, different living conditions, etc.), is the applicant emotionally stable for study abroad?

☐ Yes  ☐ No, please describe: ________________________________________________________________

4. To your knowledge, has the applicant been treated by a psychologist or psychiatrist? In such cases, a supporting letter from the treating psychologist or psychiatrist may be requested.

☐ No  ☐ Yes, please describe: ________________________________________________________________

5. Restrictions on physical activity, including exercise in a fitness facility:

☐ None  ☐ As follows: ________________________________________________________________

I have examined the above-named applicant and consider him/her physically qualified to participate in study at the Hebrew University.

Name of Physician ___________________________ (please type or print) _____

Address ____________________________________________

Signature of Physician ____________________________________________

Telephone ____________________________________________

License No. ___________________________ Date ___________________________

Please return the completed form to:
Office of Academic Affairs • One Battery Plaza, 25th Floor • New York NY, 10004
Tel: 1 800-404-8622 or 1 212-607-8520 • Fax: 1 212-809-4183 • E-mail: hebrewu@hebrewu.com
健康診断書 Health Certificate
(診断医に記入してもらってください/to be completed by the examining physician)

日本語又は英語により明確に記載すること。Please fill out (PRINT/TYPe) in Japanese or English.

氏名 Name: ____________________________
Gender: □ Male □ Female Date of Birth: __________ Year / Month / Day

1. 身体検査
Physical Examination

(1) 身長 Height cm 体重 Weight kg

(2) 血圧 Blood pressure mmHg~ mmHg 血液型 Blood type

ABO RH+ 漱拍 Pulse □ 正常 regular

(3) 視力 Eyesight: (R) (L)

視眼 Without glasses 視正 With glasses or contact lenses

(4) 聴力 Hearing: □ 正常 normal 言語 Speech: □ 正常 normal

2. 聴診の胸部について、聴診とX線検査の結果を記入してください。X線検査の日付も記入すること（6ヶ月以上前の検査を無効）
Please describe the results of physical and X-ray examinations of the applicant’s chest X-rays (X-rays taken more than 6 months prior to this certificate are NOT valid).

肺 Lungs: □ 正常 normal □ 異常 impaired
心臓 Cardiomegaly: □ 正常 normal □ 異常 impaired

Date

異常がある場合 in case “impaired”
心電図 Electrocardiograph: □ 正常 normal □ 異常 impaired

Film No.

3. 現在治療中の病気
Under medical treatment at present □ Yes (Conditions/particulars: ) □ No

4. 既往歴 Past history: Please indicate with + or − and fill in the date of recovery

Tuberculosis...□( . . ) Malaria...□( . . ) Other communicable disease...□( . . )
Epilepsy...□( . . ) Kidney disease...□( . . ) Heart disease...□( . . )
Diabetes...□( . . ) Drug allergy...□( . . ) Psychosis...□( . . )
Functional disorder in extremities...□( . . )

5. 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は充分に留学に耐えうるものと思われますか？Yes又はNoにチェックをしてください。
In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan?

Yes □ No □

6. 特記すべき事項
Particulars or additional comments:

日付 Date: ____________________________ 署名 Signature: ____________________________

医師 氏名 Physician's Name: ____________________________

診療施設名 Office/Institution: ____________________________

所在地 Address: ____________________________
This page left intentionally blank.
Certificate of Health

All sections must be filled in. Where □ is provided, please tick off appropriate box.

### Personal Information

<table>
<thead>
<tr>
<th>Name in English</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Surname)</td>
<td>(Given Name)</td>
<td>(Middle Name)</td>
</tr>
</tbody>
</table>

Date of Birth

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Year)</td>
<td>(Month)</td>
<td>(Day)</td>
</tr>
</tbody>
</table>

Sex

- □ Male
- □ Female

Current Address

Phone Number

### Examination Report

<table>
<thead>
<tr>
<th>Height</th>
<th>cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>kg</td>
</tr>
</tbody>
</table>

Eyesight

- Without Glasses:
  - Left □
  - Right □
- With Glasses or Contact Lenses:
  - Left □
  - Right □

Blood Pressure

<table>
<thead>
<tr>
<th></th>
<th>mmHg</th>
</tr>
</thead>
</table>

Urine Test

<table>
<thead>
<tr>
<th>Protein</th>
<th>Sugar</th>
<th>Blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

Chest X-ray Examination

- □ Normal
- □ Impaired

*Required

Date:

Disease currently being treated

- □ No
- □ Yes

If marked Yes, please describe in detail (medication and treatment):

Past Medical History

- □ No
- □ Yes

If marked Yes, please describe in detail:

Disabilities

- □ Negative
- □ Positive

If marked positive, please describe in detail:

### Diagnosis

In my opinion, this applicant is able to participate fully in the school program.

- □ Yes
- □ No

Date of Examination

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Year)</td>
<td>(Month)</td>
<td>(Day)</td>
</tr>
</tbody>
</table>

Name of Institution:

Address:

Name and Title of Physician (please print):

Signature/Seal of Physician:
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INTERNATIONAL CHRISTIAN UNIVERSITY

HEALTH REPORT

注意：この問診票は皆さんの健康管理（健康診断・健康相談）に役立てるものです。
記入内容については秘密を守り、皆さんの健康管理以外には使用致しません。
入学日前6ヶ月以内に医師の診断を受け、検査項目はもれなく記入して下さい。
日本国内での治療・検査・薬の処方は、母国と全く同様の診療・薬の処方などのケアが受けられない場合
があります。滞在期間中に必要な薬は、ご持参下さい。

Note: This form is for use in health management (check-ups, consultations, etc.). Information received will be
strictly protected and will not be used for any other purpose than for managing your health.
Please have a check-up with your physician 6 months prior to the date of matriculation and have
this form completed (omitting no section). Please understand that there may be instances in which

treatment, examinations and medicine in Japan may differ from the care received in your home country.
You should bring any medicine you will need during your stay in Japan.

楷書でご記入ください / PLEASE WRITE LEGIBLY

<table>
<thead>
<tr>
<th>氏名 (Family)</th>
<th>姓 (Family)</th>
<th>名 (Given)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>生年月日</th>
<th>Date of Birth</th>
<th>19 ________ 年 ________ 月 ________ 日</th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>緊急連絡先 (保護者など)</th>
<th>Contact Information in case of Emergency (Parent or Guardian)</th>
</tr>
</thead>
<tbody>
<tr>
<td>氏名</td>
<td>Name</td>
</tr>
<tr>
<td>電話番号</td>
<td>Phone No.</td>
</tr>
</tbody>
</table>

医師記入欄 / TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER (NOT PARENT)
楷書でご記入ください / PLEASE WRITE LEGIBLY

1. 身長 Height cm.
2. 体重 Weight kg.
3. 視力 Vision Normal Abnormal Please describe
   □ □ □
   Uncorrected Corrected
4. 聴覚 Hearing Normal Abnormal Please describe
   □ □ □
5. 検尿 Urinalysis Protein Sugar
   □ □
   Blood Pressure
6. 血圧

7. 胸部エックス線検査またはツベルクリン反応：以下のAまたはBのいずれかを記載してください。
   Chest x-ray OR tuberculin skin test. Please fill out one of the following (A or B).

A. 胸部エックス線検査 Chest x-ray
   - 6ヶ月以内のものに限る
   - Must have been taken within 6 months
   撮影年月日 Date of exam
   所見 : 正常 / 異常 Findings: Normal / Abnormal
   □ □
   Please describe

B. ツベルクリン反応 Tuberculin skin test
   - 6ヶ月以内のものに限る
   - Must have been taken within 6 months
   検査日 Date of test
   結果
   Results Negative Positive
   □ □
   * 陽性の方は胸部エックス線検査も併せて受けてください。
   * Individuals who tested positive for the tuberculin skin test should also have a chest x-ray.

※裏面もご記入ください。《OVER》
8. 主な既往症と罹患時の年齢（気管支喘息、心臓病、てんかん等）
   Medical history and dates of illnesses (bronchial asthma, cardiac disease, epilepsy, etc.)

9. 現在治療中の疾患や障害
   Disease or disorder currently under treatment

10. その他・特記事項（アレルギーの有無、持参薬）
    Other (allergies, medication)
    注意: 日本にはない薬もあります。常用薬のある方は、日本滞在期間中薬を必ず持参下さい。
    また、滞在中治療、検査や処方が必要と思われる場合は、英文の医師の診断書をご持参下さい。
    NOTE: Medicine this person is currently taking may not be available in Japan. Those who are on
    medication should bring any necessary medicine for the duration of his/her stay in Japan.
    If it is expected that this person will need medical care while in Japan, he/she should bring
    medical certificate in English issued by his/her physician.

11.予防接種歴 以下の病気になったこと、また予防接種を受けたことはありますか？
    Immunizations: Has this person ever had the following diseases or received vaccinations?

<table>
<thead>
<tr>
<th>罹患 Disease</th>
<th>予防接種 Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1回目</td>
</tr>
<tr>
<td>MMR</td>
<td>Yes / No</td>
</tr>
<tr>
<td>麻疹 Measles</td>
<td>Yes / No</td>
</tr>
<tr>
<td>風疹 Rubella / German Measles</td>
<td>Yes / No</td>
</tr>
<tr>
<td>流行性耳下腺炎 Mumps</td>
<td>Yes / No</td>
</tr>
<tr>
<td>水痘 Varicella / Chicken pox</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

診断の結果上記のとおり相違ないことを証明する。
I certify that this person's physical condition is as stated above.

医療機関名及び住所(所在地)
Name and location of medical organization

年月日  Date: yy/mm/dd

医師氏名(楷書)
Name of physician
(Please write legibly)

医師署名
Physician's signature
日本 - Keio

健康診断書
Certificate of Health

注意事項 IMPORTANT NOTE
この健康診断書は、現在の健康状態で問題なく留学生活を送れるかどうかを把握するためものです。
医師に診断を受け正確に記入してもらう事で、中学生の医学を確認していただき、診断を受けた

The purpose of this form is to understand the student’s health conditions that may affect his/her studies before he/she comes to Japan.
This form must be completed by a medical physician. If a student does not have antibodies against the infectious diseases listed below, we strongly recommend that he/she gets vaccinated.

診断日 Date

医療機関名 Institution/Clinic

所在地 Address

医師氏名 Name of Physician

署名 Signature

<table>
<thead>
<tr>
<th>氏名 Name</th>
<th>姓 Family</th>
<th>名 Given</th>
<th>ミドルネーム Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>生年月日 Date of Birth</td>
<td>19</td>
<td>年</td>
<td>月</td>
</tr>
<tr>
<td>性別 Sex</td>
<td>□ 男 Male</td>
<td>□ 女 Female</td>
<td></td>
</tr>
</tbody>
</table>

診断事項・健康の状態 Examination Report・Current State of Health

視力 Eye-sight

左 (L) 右 (R) □ 裸眼 Without glasses or contact lenses □ 矯正 With glasses or contact lenses

聴力 Hearing

☑ 正常 Normal □ 異常 Impaired

胸部X線検査 Chest X-ray

※1年以内に実施したPPDまたはIGRA検査（結核の血液検査）の結果、陰性だった場合には、胸部X線は省略可。

Chest X-ray can be omitted if the results of an examination for PPD or IGRA (TB blood test) within one year are negative.

所見があれば記入してください。Describe the condition in detail.

感染症などの病歴について Record of infectious diseases and immunization

以下の感染症にかかったこと、および予防接種を受けたことがありますか。

Has the student ever had the following diseases and/or received vaccination?

麻疹 Measles

☑ Yes □ No □ Vaccinated

Date of Recovery/Vaccination: / / 

風疹 Rubella

☑ Yes □ No □ Vaccinated

Date of Recovery/Vaccination: / / 

流行性耳下腺炎 Mumps

☑ Yes □ No □ Vaccinated

Date of Recovery/Vaccination: / / 

水痘 Varicella

☑ Yes □ No □ Vaccinated

Date of Recovery/Vaccination: / / 

学業上障害すべき健康上の問題 Medical conditions which might affect the student’s academic performance

主な既往症や持病はありますか。Does the student have any serious past medical history or chronic illness?

☑ 有 Yes □ 無 No

例:気道感染症、心臓病、てんかんなど eg: Bronchial asthma, Cardiac diseases, Epilepsy etc.

心身の疾病または障害に関する所見 Are there any physical or mental conditions that may limit the student’s ability to study?

☑ 有 Yes □ 無 No

食事・薬物アレルギーがあれば記入してください。Does the student have any food or drug allergies? If "Yes", please describe.

☑ はい Yes (Adequate)

☑ いいえ No (Inadequate)

この学生に精神的及び身体的に、海外での留学に適した状態にあると考えられています。

☑ はい Yes (Adequate)

☑ いいえ No (Inadequate)

問い合わせのための理由を述べてください。If "No", please describe the reason.
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健康診断書
CERTIFICATE OF HEALTH (to be completed by the examining physician)

日本語又は英語により明確に記載すること。
Please fill out (PRINT/TYPING) in Japanese or English.

氏名: Family name, First name, Middle name

□男 Male 生年月日: Date of Birth: 年齢: Age:

□女 Female

1. 身体検査

Physical Examination

(1) 身長: Height: cm 体重: Weight: kg

(2) 血圧 Blood pressure: mm/Hg~ mm/Hg 血液型 Blood type: A B O AB RH +

脈拍 Pulse: □整 regular □不整 irregular

(3) 視力 Eyesight: (R) (L) 拡張 Without glasses 縮小 With glasses or contact lenses

色覚異常の有無 Color blindness: □正常 normal □異常 impaired

(4) 聴力 Hearing: □正常 normal 言語: □正常 normal

言語: □不整 impaired

2. 申請者の胸部について、聴診とX線検査の結果を記入してください。X線検査の日付も記入すること（6ヶ月以上前の検査は無効。）

Please describe the results of physical and X-ray examinations of the applicant's chest x-rays (X-rays taken more than 6 months prior to this certification are NOT valid).

肺: Lungs: □正常 normal □異常 impaired

心臓: Cardiomegaly: □正常 normal □異常 impaired

異常がある場合

心電図 Electrocardiograph: □正常 normal □異常 impaired

3. 検査 Laboratory tests

検便 Urinalysis: glucose ( ), protein ( ), occult blood ( )

赤沈 ESR: mm/Hr, WBC count: /cmm 貧血 □ anemia

貧血 Hemoglobin: gm/dl, GPT: 

4. 現在治療中の病気 □Yes (Conditions/particulars: ) □No

Under medical treatment at present: □Yes  □No

5. 既往症 Past history: Please indicate with + or - and fill in the date of recovery

肺製 Paragonimiasis......□( . . ) 疟疾 Malaria......□( . . ) □其他 communicable disease......□( . . )

エイズ HIV ......□( . . ) □不整 irregular

精神障害 Psychosis ......□( . . ) □不整 irregular

6. 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は充に留学に耐えうるものと思われますか？ Yes又はNoにチェックをしてください。

In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan?

Yes □ No □

7. 特記すべき事項

Particulars or additional comments:

日付 Date: 医師署名: Physician's Signature:

医師氏名: Physician's Name (Print):

在住地: Address:

検査施設名: Office/Institution:
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Appendix Declaration of intent to undergo a TB test

In order to obtain a residence permit, you (or the person you represent) must be prepared to undergo a tuberculosis (TB) test and - if necessary - treatment. If you submit the completed declaration of intent to undergo a TB test to the IND together with your application (and also meet all other conditions), the IND will grant you a residence permit as soon as possible.

You are granted this permit under the express condition that you will actually undergo a TB test within three months. Should it become clear after the issue of a residence permit that - despite signing the declaration of intent - you failed to undergo a TB test within the period of three months, this may result in a cancellation of the permit that was granted.

Enclose the completed and signed declaration of intent with your application before you make an appointment with the Municipal Health Service. In doing so, you declare that you are prepared to undergo a TB test and, if necessary, TB treatment. For the appointment with the Municipal Health Service, you must complete the referral form as much as possible (part 1) and take it with you.

The obligation to undergo the test does not apply if you are a national of one of the following countries: one of the Member States of the EU or the EEA, Australia, Canada, Israel, Japan, Monaco, New Zealand, Suriname, United States of America and Switzerland (including Liechtenstein). Nor does the obligation to undergo the test apply if you have an EU residence permit for long-term residents issued by another EU country or are his/her family member and were already admitted to another EU country as a family member of the long-term resident.

1 Details of foreign national to be tested (the applicant)

1.1 Application for a permit for the purpose of work, wealthy foreign national, learning while working or study? Yes No

1.2 V-number (leave blank)

1.3 Name Surname as stated in the border-crossing document

First names

1.4 Sex and Date of birth

> Please tick the applicable situation

Day Month Year

Male Female

1.5 Place of birth
1.6 Country of birth
1.7 Nationality
1.8 Home address Street Number

Postal code Town

1.9 Civil status

> Please tick the applicable situation

unmarried married registered partnership divorced

widow/widower

1.10 Details border-crossing document

Number Country

Valid from (date) Valid till (date)

1.11.1 Do you have a spouse or (registered) partner?

No > Go to 2 'Signing'

Spouse > Please complete the requested details below

(Registered) partner > Please complete the requested details below
This page left intentionally blank.
# Malaria Contract Addendum (Africa)

This form is important. All Ghana, Senegal and Tanzania participants **must** sign this form.

<table>
<thead>
<tr>
<th>Name (please print):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Program:</th>
<th>○ Ghana</th>
<th>○ Senegal</th>
<th>○ Tanzania</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Term(s) – check all that apply:</th>
<th>○ Spring</th>
<th>○ Fall</th>
<th>○ Summer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year(s) – check all that apply:</th>
<th>○ 2015</th>
<th>○ 2016</th>
<th>○ 2017</th>
<th>○ Other: ____________________________</th>
</tr>
</thead>
</table>

## Consent and Commitment to Utilization of Prophylactics against Malaria

Malaria is endemic in Ghana, Senegal and Tanzania. Unless malaria prophylactics are taken faithfully as prescribed there is a significant risk of contacting a serious or fatal disease. Consequently, **CIEE will not accept you or retain you in this program if you do not agree to take anti-malaria medication as prescribed.** The only exception to this rule is if you produce a statement from your doctor prior to the commencement of this program that, for other medical reasons, your doctor recommends against your taking any malaria prophylactic.

Please sign the form below and return it to us with your application materials.

I agree to take prophylactic anti-malaria medication regularly as prescribed unless prior to the beginning of the program, I submit to CIEE a statement from my doctor recommending against my taking said medication.

---

**Signature of Participant**

**Date**

---

**Signature of parent of guardian of participant if participant is under the age of majority in the jurisdiction where this document is signed.**

**Date**
CIEE – Supplemental Medical Release Form

This Medical Release form is supplemental and not in substitution of the CIEE Student Medical Form which I signed on or about ____________.

I am voluntarily opting to study abroad in Dakar, Senegal although I have disclosed that I have a serious allergy to peanuts. I understand that peanuts and/or their derivatives are used in virtually all Senegalese dishes. I agree to release CIEE from any liability for any medical issues or other problems that may result from this allergy during my time on the CIEE Dakar Language and Culture program. Further, I understand that CIEE will not be able to guarantee a peanut-free environment or peanut-free meals during my time on the program.

I understand that health issues stemming from my peanut allergy must not interfere with attendance in classes or with my participation in any CIEE obligatory and optional events and understand and accept that CIEE has the right to dismiss me from the program at any time if my allergy results in health issues or related problems that require significant on-going care by CIEE resident staff and my CIEE homestay family.

Student Name: __________________________

Student Signature: _______________________

Date: _________________________________
MEDICAL EXAMINATION REPORT

For New Applicants:
1. The Medical Examination may be done in Singapore by any registered General Practitioner (GP). Applicants who are in their home countries/places of residence may have their Medical Examination and HIV test done in their home countries/places of residence at any medical clinic licensed to carry out such tests. If HIV testing is done in Singapore, it may be carried out with either rapid or ELISA tests.

For Renewal Applicants:
1. The Medical Examination MUST be done in Singapore by any registered GP. HIV testing may be done with either rapid or ELISA tests.

Notes for All:
1. This Medical Examination Report is to be completed by a registered doctor and returned to the examinee. The original copy of the laboratory report for HIV and the X-ray report must be attached to this Medical Examination Report only if the medical examination and testing is carried out overseas.
2. The laboratory report for HIV and the X-ray report submitted to the Immigration & Checkpoints Authority should be within THREE MONTHS from the date of the issue of the reports.

I Personal Particulars

1. Name (as in the passport):
2. Sex: M / F
3. Date of Birth:
4. Nationality:
5. Passport No.:
6. FIN No. (if applicable):
7. Address in Singapore:

II Medical Examination

I certify that the above-named has undergone a chest x-ray and the result of his/her chest X-ray is as indicated (with a [✓]):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>![TB (Chest X-ray)*](active TB detected?)</td>
<td>![active TB detected?](active TB detected?)</td>
</tr>
</tbody>
</table>

1. Any evidence of active TB detected?

For persons screened overseas, the name in the laboratory report for HIV and the X-ray report must be according to the name shown in the Passport.

I certify that I have tested the above-named and the result of his/her HIV test is indicated below (with a tick [✓]):

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative/Non-Reactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>![HIV](Positive HIV)</td>
<td>![HIV](Negative HIV)</td>
</tr>
</tbody>
</table>

Name of Examining Doctor (IN BLOCK LETTERS):

Signature: ____________________________
Clinic’s Stamp & Address: ____________________________
Date: ____________________________
Telephone Number: ____________________________
MCR no: ____________________________

WARNING: IT IS AN OFFENCE UNDER THE IMMIGRATION ACT TO MAKE ANY FALSE STATEMENT, REPRESENTATION OR DECLARATION

DECLARATION

I, ____________________________ declare that the above is not applicable to me as ____________________________

I have submitted a medical report** containing the above information to Immigration & Checkpoints Authority / Ministry of Manpower*** (not more than two years ago) when I was granted the ____________________________

on ____________________________ valid till ____________________________

Signature & Date

** Those who were previously exempted from submitting the X-ray report because of pregnancy are required to submit a X-ray report certified by a Singapore registered GP, if you are not pregnant now.
*** Delete where necessary.
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REPUBLIC OF SOUTH AFRICA  
DEPARTMENT OF HOME AFFAIRS  
MEDICAL CERTIFICATE  

CONDITIONS OF A RECURRENT NATURE  
Although the person(s) may be generally in a good state of health at the time of the examination, it would be appreciated if the medical officer/practitioner could furnish details of any disease, condition or defect the person(s) has/have suffered and which might recur.

I hereby certify that I have examined the following person(s):

1. ........................................................................
2. ........................................................................
3. ........................................................................
4. ........................................................................
5. ........................................................................
6. ........................................................................
7. ........................................................................
8. ........................................................................

and find him/her/them—
(a) not mentally disordered* or physically defective in any way;
(b) not suffering from leprosy, venereal disease, trachoma, or other infections or contagious condition;
(c) generally in a good state of health;

except for the following defects observed:

(Please type or print)

<table>
<thead>
<tr>
<th>Name of person(s)</th>
<th>Details regarding the disorder, disease or disability, the seriousness thereof and the treatment, if any, prescribed/recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Official stamp and address of medical officer/practitioner/hospital

Signature of medical officer/practitioner

Date

Int. code  
290–299 All psychoses.
300 Neuroses.
301 Personality disorders.
303–304 Addictions.
308 Behaviour disturbances of childhood.
310–315 All forms of mental retardation.
320–349 Epilepsy and all other forms of degeneration of the central nervous system.

* “Mentally disordered” includes the following:
Note:

(1) A radiological report of the chest is required in respect of every prospective immigrant 12 years of age and over.

(2) The radiologist must insert the names of the prospective immigrants examined by him in the space provided for that purpose on the form. Unused spaces must be crossed out.

(3) A separate report is required in respect of every applicant suffering or suspected to be suffering from tuberculosis.

I hereby certify that I have radiologically examined the chest(s) of the following person(s) and that I could find no signs of active pulmonary tuberculosis.

Name:

(1) __________________________________________

(2) __________________________________________

(3) __________________________________________

(4) __________________________________________

(5) __________________________________________

(6) __________________________________________

_____________________________________

Radiologist

Official stamp and address of Radiologist/Hospital:

Date: __________________________________________

__________________________________________

__________________________________________

__________________________________________
健康檢查證明書

**Items Required for Health Certificate (Type B)**

(National Name, Hospital’s Name, Address, Tel, FAX)

**Basic Data (BASIC DATA)**

<table>
<thead>
<tr>
<th>姓名</th>
<th>性別</th>
<th>性別</th>
<th>國籍</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Sex (Male)</td>
<td>Sex (Female)</td>
<td>Nationality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>身份證字號</th>
<th>護照號碼</th>
<th>出生年月日</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID No.</td>
<td>Passport No.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Laboratory Examinations (LABORATORY EXAMINATIONS)**

A. HIV 類檢 (Serological Test for HIV Antibody): □陽性 (Positive) □陰性 (Negative)
   □未確定 (Indeterminate)
   a. 醫學 (Screening Test): □EIA □Serodia □其他 (Others) __________
   b. 確診 (Confirmatory Test): □Western Blot □其他 (Others) __________

B. 胸肺 X 光檢查 (Chest X-Ray for Tuberculosis): (妊娠婦女可免接受「胸肺 X 光檢查」)
   □正常 (Normal) □異常 (Abnormal) __________
   ■限大片攝影 (Standard Film Only)

C. 腹內寄生蟲 (含糞便阿米巴等病原蟲) 異常檢查（採用離心濃縮法檢查） (Stool examination for parasites includes *Entamoeba histolytica* etc.) (centrifugal concentration method):
   □陽性，種名 (Positive, Species) __________ □陰性 (Negative)

D. 梅毒血清檢查 (Serological Test for Syphilis): □陽性 (Positive) □陰性 (Negative)
   a. □RPR b. □VDRL c. □TPHA/TPPA d. □其他 (Other)

E. 腸道及河馬病之體部陽性反應報告或預防接種證明 (proof of positive measles and rubella antibody titers or measles and rubella vaccination certificates):
   a. 抗體检查 (Antibody test) 麻疹病原體 measles antibody titers □陽性 Positive □陰性 Negative
   德國麻疹病原體 rubella antibody titers □陽性 Positive □陰性 Negative

b. 預防接種證明 Vaccination Certificates
   □麻疹預防接種證明 Vaccination Certificates of Measles
   □德國麻疹預防接種證明 Vaccination Certificates of Rubella

c. □經醫師評估，有接種禁忌者，暫不適宜接種 (Having contraindications, not suitable for vaccination)

**Examination for Hansen’s Disease**

漢生病情診結果 (Skin Examination) □正常 Normal □異常 Abnormal (※視診異常者，須進一步採檢確認)

(※If abnormal skin lesion is found, further skin biopsy or skin smear is required)

a. 機理切片 (Skin Biopsy): □陽性 (多菌，少菌) □陰性 (Negative)
   □陽性 Positive □陰性 Negative

b. 皮膚抹片 (Skin Smear): □陽性 (Finding bacilli in affected skin smears) □陰性 (Negative)

※ 皮膚病灶合併感覺喪失或神經腫大 (Skin lesions combined with sensory loss or enlargement of peripheral nerves)
   □有 (Yes) □無 (No)

**Year Students Only - Taiwan**

備註 (Note):

1. 本表供外籍人士等申請在台灣定居或居留時使用，This form is for *residence application*.
2. 兒童 6 歲以下免辦理健康檢查，但須提交預防接種證明備案 (年滿 1 歲以上者，至少接種 1 副麻疹、德國麻疹疫苗).
   A child under 6 years old is not necessary to have laboratory examination, but the certificate of vaccination is necessary. Child age one and above should get at least one dose of measles and rubella vaccines.
3. 妊娠婦女及年滿 15 歲以上免接受「胸肺 X 光檢查」，Pregnant women and children under 12 years of age are exempted from chest X-ray examination.
4. 兒童 15 歲以下免接受「HIV 抗體檢查」及「梅毒血清檢查」，A child under 15 years old is not necessary to have Serological Test for HIV or Syphilis.
5. 居住於北美洲、歐洲、紐西蘭、澳洲、日本、南韓、香港、澳門及新加坡等地區或國家之申請者，得免驗腸內寄生蟲異常檢查。Applicants living in Northern America, Europe, New Zealand, Australia, Japan, South Korea, Hong Kong, Macao or Singapore are not required to undergo a stool examination for parasites.
六、結論：根據以上對________________先生/女士/小姐之檢查結果為□合格 □不合格。

Result: According to the above medical report of Mr./Mrs./Ms. ______________________, he/she has

□passed □failed the examination.

負責診療師簽章： ____________________________ (Name & Signature)

（Chief Medical Technologist）

負責醫師簽章： ____________________________ (Name & Signature)

（Chief Physician）

醫院負責人簽章： ____________________________ (Name & Signature)

（Superintendent）

日期（Date）： __________ / __________ / ________ 本證明三個月內有效（Valid for Three Months）

附錄：健康檢查證明不合格之認定原則

<table>
<thead>
<tr>
<th>檢查項目</th>
<th>不合格之認定原則</th>
</tr>
</thead>
</table>
| 人禽免疫缺乏病毒抗體測定 | 一、人禽免疫缺乏病毒抗體測定經初步測試，連兩次呈陽性反應者，應以西方漬點法(WB)作確認試驗。
二、連續二次採血時間間隔三個月之西方漬點法結果皆為未確定者，視為合格。 |
| 胸部X光檢查 | 一、活動性肺結核(包括結核性胸膜炎)視為「不合格」。
二、非活動性肺結核視為「合格」，包括下列診斷情形：纖維化(鈣化)肺結核、纖維化(鈣化)病灶及肋膜增厚。 |
| 腸內寄生蟲蟲便檢查 | 一、經腸道検査結果胃道蠕蟲蟲卵或其它原蟲蟲如：痢疾阿米巴原蟲 (Entamoeba histolytica)、鞭毛原蟲類、纖毛原蟲類及孢子蟲類者為不合格。
二、經腸道検査結果為人寄生原蟲及阿米巴原蟲類，如：哈氏阿米巴 (Entamoeba hartmanni)、大腸阿米巴 (Entamoeba coli)、微小阿米巴 (Endolimax nana)、嗜碘阿米巴 (Iodamoeba buschlii)、雙核阿米巴 (Dientamoeba fragilis) 等，可不予治療，視為「合格」。
三、如懷孕婦女如寄生蟲檢查陽性者，視為合格；請於分娩後，進行治療。 |
| 梅毒血清檢查 | 一、以 RPR 或 VDRL 其中一種加上 TPHA(TPPA)之檢查，如檢查結果有下列情形任一者，視為「不合格」：
(一) 活性梅毒：同時符合條件 (一) 及 (二)、或僅符合條件 (三) 者。
(二) 非活性梅毒：僅符合條件 (二) 者。
二、二件或以上有陽性反應者，總反應陽性反應者，經進一步診斷，視為「不合格」。 |
| 瘧疾、德國瘧疾 | 瘧疾、德國瘧疾抗體陰性且未具備瘧疾、德國瘧疾預防接種證明者為不合格。但經醫師評估有瘧疾、德國瘧疾接種禁忌者，視為合格。 |

Appendix: Principles in determining the health status failed

Test Item | Principles on the determination of failed items |
---|---|
Serological Test for HIV Antibody | 1. If the preliminary testing of the serological test for HIV antibody is positive for two consecutive times, confirmation testing by WB is required. 2. When findings of two consecutive WB testing (blood specimens collected at an interval of three months) are indeterminate, this item is considered qualified. |
Chest X-ray | 1. Active pulmonary tuberculosis (including tuberculous pleurisy) is unqualified. 2. Non-active pulmonary tuberculosis including calcified pulmonary tuberculosis, calcified foci and enlargement of pleura, is considered qualified. |
Stool Examination for Parasites | 1. By microscope examination, cases are determined unqualified if intestinal helminthes eggs or other protozoa such as Entamoeba histolytica, flagellates, ciliates and sporozoans are detected. 2. Blastocystis hominis and Amoeba protozoa such as Entamoeba hartmanni, Entamoeba coli, Endolimax nana, Iodamoeba buschlii, Dientamoeba fragilis found through microscope examination are considered qualified and no treatment is required. 3. Pregnant women who have positive result for parasites examination are considered qualified and please have medical treatment after delivery. |
Serological Test for Syphilis | 1. After testing by either RPR or VDRL, if cases meet one of the following situations are considered failing the examination.
(1) Active syphilis: must fit the criterion (1) + (2) or only the criterion (3).
(2) Inactive syphilis: only fit the criterion (2).
2. Criterion: (1) Clinical symptoms with genital ulcers (chancres) or syphilis rash all over the body. (2) No past diagnosis of syphilis, a reactive nontreponemal test (i.e., VDRL or RPR), and TPHA(TPPA) = 1 : 320 (including 1 : 320). (3) A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer. 3. Those that have failed the serological test for syphilis but have submitted a medical treatment certificate are considered passing the examination. |
Measles, Rubella | The item is considered unqualified if measles or rubella antibody is negative and no measles, rubella vaccination certificate is provided. Those who having contraindications, not suitable for vaccinations are considered qualified. |

10/28/2009 修订
# 國立臺灣大學交換暨訪問學生一般體格檢查表

**NTU Incoming Exchange / Visiting Students Health Exam Form**

<table>
<thead>
<tr>
<th>姓名 Name</th>
<th>性別 Sex: □ 男 Male □ 女 Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>生日 Date of Birth: ____ 年 Y/ ____ 月 M/ ____ 日</td>
<td>相片</td>
</tr>
<tr>
<td>居留證或護照號碼 ARC or Passport No.</td>
<td></td>
</tr>
<tr>
<td>系所 Department:</td>
<td>學號 Student ID:</td>
</tr>
</tbody>
</table>

### 個人病史 Personal History

| 食物 Food allergies | 藥物過敏 Drug allergies (名稱 Item name: ) |

<table>
<thead>
<tr>
<th>理學檢查 Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>身高 Height: cm</td>
</tr>
<tr>
<td>血壓 Blood Pressure: / mmHg</td>
</tr>
<tr>
<td>皮膚 Skin:</td>
</tr>
<tr>
<td>胸部 Chest:</td>
</tr>
<tr>
<td>腹部 Abdomen:</td>
</tr>
<tr>
<td>口腔 Oral Cavity:</td>
</tr>
<tr>
<td>肌肉、骨、關節 Muscles/Bones/Joints:</td>
</tr>
</tbody>
</table>

### 視力 Visual Acuity:

<table>
<thead>
<tr>
<th>裸視 Uncorrected ( R L )</th>
<th>矯正 Corrected ( R L )</th>
</tr>
</thead>
</table>

### 辨色力 Color Differentiation:

| □無異常 Normal | □異常 Abnormal |

### 聽力 Hearing: 右 Right | 未通過 Pass | 未通過 Fail / 左 Left | 未通過 Pass | 未通過 Fail |

### 實驗室檢查 Laboratory Examinations

<table>
<thead>
<tr>
<th>肝功能 ALT: U/L</th>
<th>空腹血糖 AC sugar: mg/dL</th>
<th>白血球數 WBC: K/μL</th>
</tr>
</thead>
<tbody>
<tr>
<td>肌酸酐 Creatinine: mg/dL</td>
<td>尿酸 Uric acid: mg/dL</td>
<td>血紅素 Hb: g/dL</td>
</tr>
<tr>
<td>蛋白 T-cholesterol: mg/dL</td>
<td>三酸甘油脂 Triglycerides: mg/dL</td>
<td>血小板數 Platelet: K/μL</td>
</tr>
</tbody>
</table>

**尿液 Urine:**

| 尿蛋白 Protein | 尿糖 Sugar | 尿潛血 Fecal Occult Blood |

### 胸部 X 光 Chest X-Ray (限大片 Standard Film Only): **

| 個案目前是否因疾病服用藥物或接受治療 Is the student taking medications or treatment for any disease: |

### 總評及建議 Comments and Suggestions:

**醫師簽章 Doctor’s signature:**

**證書字號 Professional Identification number:**

**檢查日期 Date of health exam:**

**體檢醫療院所名稱 Name of the medical institution for the health exam:**

**請務必加蓋機關印章，否則視同無效。** Not valid if without the institution’s seal.

**※ 醫師理學評估檢查，胸部 X 光檢查為必要項目( Physical exam by physicians and Chest X-ray exam are mandatory items)**
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Malaria Contract Addendum (Africa)

This form is important. All Ghana, Senegal and Tanzania participants must sign this form.

Name (please print): ___________________________

Program:   ○ Ghana  ○ Senegal  ○ Tanzania

Term(s) – check all that apply:   ○ Spring  ○ Fall  ○ Summer

Year(s) – check all that apply:   ○ 2015  ○ 2016  ○ 2017  ○ Other: ___________________________

Consent and Commitment to Utilization of Prophylactics against Malaria

Malaria is endemic in Ghana, Senegal and Tanzania. Unless malaria prophylactics are taken faithfully as prescribed there is a significant risk of contacting a serious or fatal disease. Consequently, CIEE will not accept you or retain you in this program if you do not agree to take anti-malaria medication as prescribed. The only exception to this rule is if you produce a statement from your doctor prior to the commencement of this program that, for other medical reasons, your doctor recommends against your taking any malaria prophylactic.

Please sign the form below and return it to us with your application materials.

I agree to take prophylactic anti-malaria medication regularly as prescribed unless prior to the beginning of the program, I submit to CIEE a statement from my doctor recommending against my taking said medication.

Signature of Participant ___________________________  Date ___________________________

Signature of parent of guardian of participant if participant is under the age of majority in the jurisdiction where this document is signed.

______________________________  Date ___________________________
UCEAP Annual Health Update 2015-2016

END

This document is available electronically at www.eap.ucop.edu/Documents/HealthClearance/1516/annual_health_update.pdf