Creighton UNIVERSITY
Global Engagement Office

Creighton UNIVERSITY
Division of Student Life
Student Health Services

GLOBAL ENGAGEMENT OFFICE (GEO)
Health Clearance Instructions

(To Be Reviewed by the **Student & Health Provider**)

Health Clearance Requirement: Obtaining a health clearance is a requirement to participate in any travel abroad program for which you will receive Creighton University sponsorship or credit. If you do not comply with this requirement, you will not be approved to participate in, or may be dismissed at your own expense from, the travel abroad program.

If your travel abroad program is administered by another organization or institution, *and* the administering organization or institution will collect health information from you using its own processes, then you are exempt from obtaining a Creighton University Health Clearance.

General Requirements of Travel Abroad Program Participation: In addition to meeting all specific requirements of the travel abroad program chosen (as set forth in the program description), all participants must meet the following general requirements of program participation:

- Possess the physical and mental well-being required to: live/study in the applicable foreign setting where resources may be different or fewer than those to which they are accustomed; exercise good judgment; and safely fulfill all essential components of the travel abroad program, including appropriate standards of conduct.
- Be able to display flexibility and to function in potentially uncertain or stressful situations.
- Be able to align their health care needs with the limited resources that may exist at a nearby health care facility.
- Be able to live in a setting quite different from that to which they may be accustomed and that may aggravate any existing health conditions (e.g., dormitories or residences that may not be air-conditioned, homestays with local families, etc.).
- Participate in typical classroom activities (such as assigned readings, written assignments, classroom discussions, written and/or oral examinations, etc.) with or without reasonable accommodation.
- Participate in program related excursions and activities, which may include moderate activities such as hiking, walking, and/or other recreational sports and in some cases more strenuous activities, where heat or cold may be a factor, based in the particular travel abroad program.
- Consider that travel abroad can impose extraordinary and sometimes unpredictable psychological and physical demands on you for which you should be as prepared beforehand as possible. Note that some accommodations may not be feasible depending on the type and location of program you have applied to. It is usually in the student's best interest to request a reasonable accommodation before initiating travel to make sure such accommodations can be put in place.

Confidentiality:
Obtaining health clearance is a mandatory requirement for participation. Creighton University must receive accurate information about your physical and mental abilities to participate in the travel abroad program you have chosen. Information that the Creighton Global Engagement Office receives about you is confidential and will be shared only with those who need to know in order to assist you when you are abroad. Completed forms will be reviewed by Student Health Services (SHS) and stored in the SHS electronic health record.

Full Disclosure:
It is extremely important to disclose all of your medical history to any health provider(s) who complete your Health History/Clearance Form, even if you do not believe that a condition might create a problem for you while abroad. Full disclosure will allow your health provider(s) to help you make necessary arrangements or plans to assist you in enjoying a successful experience. *Failure to provide complete and accurate information to your health provider(s) or to Creighton University may be grounds for you to be barred from participation in, or dismissed at your own expense from, the travel abroad program you have chosen.*

For participants with known and/or chronic medical conditions:
You must take special precautions in preparing for and managing your situation abroad. You also need to discuss with your health provider how the new environment and the stresses of travel abroad may affect your health. *Preexisting mental health conditions are often intensified by living in a different culture. There may be very few if any local resources to help a participant manage potential triggers.* You should

discuss these concerns with your health provider(s) before your departure and fully explore what, if anything is available to address your health concerns in the location you will be visiting.

For participants using medication:

- If you use medication on a regular basis (such as asthma inhalers or other daily prescription medication) you should take a sufficient supply to last throughout your stay.
- When going through customs abroad, officials may scrutinize prescription medication. Carry your prescription in original containers with a letter from your health provider. Medications that are legal and readily available in the U.S. may be considered illegal and/or may require an additional prescription or host country authorization. It is your responsibility to find out whether your prescription medication is available and legal at your destination. Refer to "Mailing medication abroad," below.
- If you are taking a medication for an ongoing health condition, you must be medically stable on your medication before starting your travel abroad experience. "Medically stable" means that no changes in your symptoms are foreseen or expected. Discuss proper medication management with your health provider.

Mental health conditions:

If you are being treated for a mental health condition, work closely with your health provider(s) to understand possible triggers, what medications you are taking and if they are available abroad, and how to reach out for help while abroad. You should have a treatment plan for receiving necessary counseling services while participating in the travel abroad program.

Mailing medication abroad:

Most countries have very strict regulations on having medications shipped abroad. Participants find that refills of regularly taken medications in the U.S. get stopped by the host country's customs. Decisions on what medications may be mailed legally into some foreign countries are made by the Host Country Government, not the U.S. Post Office. Participants should call the host country embassy or the consulate in the U.S. for questions about mailing medications abroad.

STEPS FOR STUDENT PARTICIPANTS

- **READ** this entire document.
- **SCHEDULE** an appointment (no less than 6 weeks prior to departure but no more than 6 months prior to departure) with a Creighton Student Health Services health provider or other primary care provider (MD, DO, PA, NP).
- **COMPLETE** pages 1 through 4 of the Health History/Clearance Form accurately and truthfully **before your appointment(s)** with your health provider(s) to be evaluated for health clearance.
- The health provider will need to know your lifetime vaccinations. Please **CONFIRM** that NEST contains all previously administered vaccinations. If NEST does not contain a complete record, bring any additional records to your health clearance visit.
- **TAKE: 1) any vaccination records not included in NEST, 2) these instructions and 3) the completed Health History/Clearance Form** with you to your health provider(s) to complete the remainder of the form.
- After your visit with the health provider: If your Health History/Clearance Form is completed by another health provider, submit your updated vaccination record to Creighton Student Health Services. For instructions for submission, visit www.creighton.edu/chc.
- **SUBMIT** the completed Health History/Clearance Form to the Creighton Global Engagement Office.
- **INFORM** the Global Engagement Office and the leaders of your travel abroad program of any medical or additional special needs, or changes in health that occur after you have submitted your Health History/Clearance Form.

STEPS FOR HEALTH PROVIDERS

Creighton University requires that the student be cleared to participate in the travel abroad program by a Creighton Student Health Services health provider or other primary care provider. Health providers must be licensed in the U.S. as an MD, DO, PA, or NP and cannot be an immediate family member of the participant. If a specialist is currently providing treatment and the primary care provider does not want to take responsibility for the specialists' medical judgment, each specialist also must approve and sign the Health History/Clearance Form, and provide contact information.

The Health History/Clearance Form must be completed NO EARLIER than 6 months prior to the student's departure.

Participants will be cleared for participation only if:

- in the opinion of the medical provider or specialist(s), any medical condition(s) they may have is under control;
- they have a treatment plan in place for required ongoing care while abroad;
- they have been stable on their medication for a reasonable period; and
- they have received health provider recommended vaccinations unless a medical contraindication exists.

1. The participant must: (a) present to you a Health History/Clearance Form with pages 1 through 4 completed and signed; and (b) describe the travel abroad program he/she has chosen.
2. Discuss/review the participant's health thoroughly, referring to: the Health History/Clearance Form; the participant's medical records on file; the general requirements of program participation set forth above; and the specific requirements of the travel abroad program the participant has chosen, paying particular attention to medications and immunizations that the participant may need, any allergies the participant may have, and all currently active health problems.
3. Indicate on the Health History/Clearance Form if the participant requires services to facilitate participation in the academic programs so that Creighton University can assist the participant in determining the availability of adequate services at the program site.
4. Pay special attention to any condition that will require ongoing medication or treatment while the student is abroad.
5. Pay special attention to any current or past mental health conditions or eating disorders that may be affected by travel abroad.
6. Indicate that you have discussed with the participant any health and medication management or services that would be needed abroad. Participants must take a sufficient amount of medication to last for the duration of their travel abroad program and make sure that the prescription is available and legal in the host country. You may need to write a letter for the participant to take along with any medications, describing the medication and prescription.
7. Discuss with the participant all vaccinations recommended by the Centers for Disease Control (cdc.gov/travel) for his/her travel destination(s). If your office does not provide the recommended vaccinations, please direct the participant to a facility that can provide them.
8. Keep a copy of the Health History/Clearance Form on file. Give the original signed form to the participant.

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GLOBAL ENGAGEMENT OFFICE (GEO)
Health History/Health Clearance Form

Provide this form to your health provider during your appointment so you can discuss its contents and you can receive the counseling that will best prepare you for your travel. You must complete the following information BEFORE your health clearance appointment with your health provider. Incomplete forms will not be accepted. The Creighton Global Engagement Office must be informed of any recent medical or special needs or changes in health that occur after your health clearance appointment(s) but before the start of the program.

The information you provide is confidential. Completed forms will be reviewed by Student Health Services (SHS) and stored in the SHS electronic health record. For participants of Creighton Faculty-Led Programs and Encuentro Dominicano, a copy of this form will be given to the program leader/on-site coordinator so that he/she can better assist you in the event of an emergency.

SECTION A: STUDENT INFORMATION	
STUDENT NAME **(Last, First)**	**NET ID**
DATE OF BIRTH	**GENDER**
PERMANENT ADDRESS	**CITY, STATE, ZIP**
CLASS STATUS	**PHONE**
TERM ABROAD (e.g., Fall 2018, Summer 2019)	**PROGRAM ABROAD**

SECTION B: EMERGENCY CONTACT INFORMATION - List complete contact details for a **PRIMARY emergency contact** (parents, guardians, or spouse)	
NAME OF CONTACT	**RELATIONSHIP**
STREET ADDRESS	**CITY, STATE, ZIP**
EMAIL	**HOME PHONE**
CELL PHONE	**WORK PHONE**

List complete contact details for a **SECONDARY emergency contact** (e.g., sibling, relative, friend, neighbor).	
NAME OF CONTACT	**RELATIONSHIP**
STREET ADDRESS	**CITY, STATE, ZIP**
EMAIL	**HOME PHONE**
CELL PHONE	**WORK PHONE**

SECTION C: HEALTHCARE PROVIDER CONTACT INFORMATION

In the event that you are in need of medical treatment while abroad, the health provider who is treating you in the host country may need to contact your primary care provider in the United States. Please supply the name and contact information for the health provider that would have knowledge of your medical history. This may be a Creighton Student Health Services provider or a primary care provider in Omaha or your local area.

HEALTH PROVIDER NAME	**CLINIC NAME**
CLINIC ADDRESS	**CITY, STATE, ZIP**
CLINIC PHONE	**CLINIC FAX**

SECTION D: COUNTRIES AND ACTIVITIES

COUNTRY/COUNTRIES TO BE VISITED
DATES OF TRAVEL

WILL YOU BE:	**YES/NO**
Ascending to high altitudes (>7,000 ft or 2,300 meters) in the mountains?	
Working with exposure to animals?	
Visiting rural areas?	

SECTION E: PHYSICAL OR PSYCHOLOGICAL ACCOMMODATIONS

Please describe any physical or psychological conditions that may impact your ability to participate in the travel abroad program. Include any dietary restrictions or need for accessible transportation and housing. Consider that travel abroad can impose extraordinary and sometimes unpredictable psychological and physical demands on you for which you should be as prepared beforehand as possible. Note that some accommodations may not be feasible depending on the type and location of program you have applied to. It is usually in the student's best interest to request a reasonable accommodation before initiating travel to make sure such accommodations can be put in place.

CONDITION	**ACCOMODATIONS OR SUPPORT NEEDED**

SECTION F: CURRENT MEDICATION(S)

Include any OTC medications/supplements and medication you carry for possible use (e.g. inhaler, epinephrine auto-injector). Participant is responsible for ensuring that all medications are legally permissible abroad and that a sufficient quantity is taken on the trip.

MEDICATION	REASON FOR USE	FREQUENCY OF USE

**if you need additional space, please attach additional sheet(s)

SECTION G: DRUG/FOOD/ENVIRONMENTAL ALLERGIES AND CONDITIONS

List all drug, food, and environmental allergies. Briefly describe reaction

ALLERGEN	DESCRIBE REACTION

**if you need additional space, please attach additional sheet(s)

Have you **EVER HAD (currently or in the past)**, been treated for, or hospitalized for the following:

HEALTH CONDITION	YES/NO	IF YES, EXPLAIN
Anemia		
Asthma/lung disease		
Bladder/kidney disease		
Blood clotting problems		
Cancer		
Chronic back/joint problems		
Chronic headaches (e.g., migraines)		
Chronic infections		
Diabetes		
Epilepsy/seizures		
Heart disease		
High blood pressure		
Liver/gallbladder disease		
Sickle cell disease		
Thyroid problems		
Ulcerative colitis/Crohn's		
Other chronic conditions (List)		

Have you **EVER HAD (currently or in the past)**, been treated for, or hospitalized for the following:

MENTAL HEALTH CONDITION	YES/NO	IF YES, EXPLAIN
Attention Deficit/Hyperactivity Disorder (ADHD)		
Anxiety/ panic attacks		
Bipolar disorder		
Depression		
Eating disorder (anorexia or bulimia)		
Schizophrenia		
Substance abuse (alcohol or drugs)		
Other mental health condition (List)		

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 the Creighton Global Engagement Office immediately. I understand that if I misrepresented or failed to provide the information requested on this form, I may be barred from participation in, or dismissed at my own expense from, the travel abroad program. I authorize the Creighton Global Engagement Office to share this information with my program leader/coordinators, the travel abroad program sponsor or host institution, and the health provider at the travel destination, unless I notify the Creighton Global Engagement Office in writing.

Vaccinations and other prophylactic medication may be recommended by my health provider based upon my travel destination. Unless I have a medical contraindication to receive such recommended treatment, I agree to receive the recommended vaccinations and to complete all recommended prophylactic medication. If I intentionally disregard such treatment recommendations, I understand that I may be barred from participation in, or dismissed at my own expense from, the travel abroad program. I further hereby assume each and every risk of non-immunization if I intentionally disregard such treatment recommendations, and my non-immunization status is discovered while traveling abroad.

Participant's signature: _____ **Date:** _____

I hereby authorize representatives of Creighton University and/or the host institution, if any, to consent on my behalf to the provision of emergency medical treatment, including, but not limited to the examination, diagnosis, and treatment of any emergency condition or injury I may sustain during the Program, if I am not able to consent on my own behalf. This consent shall include, but not limited to, emergency blood transfusions, surgical procedures, administration of anesthesia, and other medical tests and procedures recommended by medical authorities. I agree to be financially responsible for any medical bills incurred as a result of such emergency medical treatment.

I also give representatives of Creighton University and/or the Program or host institution, if any, permission to communicate with one another and/or my parents/guardians, university officials, immediate family members, emergency contact persons(s), medical provider(s), and/or health care professionals concerning any medical condition about which they have knowledge in conjunction with a medical emergency.

Participant's signature: _____ **Date:** _____

The participant must take this completed form to the health provider evaluating him/her for a health clearance.

(TO BE COMPLETED BY MEDICAL PROVIDER NO EARLIER THAN 6 MONTHS PRIOR TO DEPARTURE)

STUDENT NAME **(Last, First)**	**NET ID**

Health Provider Instructions:

- Please read the Health Clearance Instructions.
- Review the participant's health and discuss it thoroughly with him/her, referring to the medical history provided on this form; the participant's medical records on file; the general requirements of program participation; and the specific requirements of the travel abroad program the participant has chosen, paying particular attention to medications and immunizations that the participant may need, any allergies the participant may have, and all currently active health problems.
- If you feel that there is another health provider who has relevant information please indicate that individual's name on this form so they can be consulted before final clearance is given.
- Forms without signatures and required information will be considered incomplete and will be returned.

HEALTH PROVIDER STATEMENT:

I have reviewed thoroughly the participant's health, referring to the participant's health history provided on this form, medical records on file, and the attached program description. Based on the information contained in the participant's medical records and provided to me by the participant, both in person and on the health history provided on this form, as well as my current observation of this participant, to the best of my knowledge: (Initial all that apply below)

Initial ____ **Participant is NOT CLEARED. There are medical or mental health contraindications to participation in the travel abroad program that the participant has chosen.**

Initial ____ **Participant is CLEARED. I have reviewed the patient's medical history. There are no medical or mental health contraindications to participation in this travel abroad program. I have discussed with the participant all vaccinations recommended by the Centers for Disease Control for his/her travel destination(s).**

Initial ____ **Participant is CLEARED with the following additional considerations. I have reviewed the patient's medical history. I have discussed with the participant all vaccinations recommended by the Centers for Disease Control for his/her travel destination(s). (Explain additional considerations below)**

Participant requires an accommodation or support to assist in his/her medical/psychological conditions in order to participate in the travel abroad program. Indicate that the participant has a treatment plan in place and is stable. Please describe:

_____

_____

_____

_____

Participant requires a sufficient supply of medications to last through the duration of the travel abroad program. The participant agrees to arrange to travel with an adequate amount of the necessary medication (including medications such as epinephrine auto-injectors and other as-needed prescription medications)

Please list medications:

_____

_____

_____

Participant is allergic to certain medication(s), foods, or other substances. Please list:

_____

_____

_____

_____

_____

_____ _____

Printed Name of Health Provider License #

_____ _____

Signature of Health Provider Date

_____

Clinic Address or Stamp: Street Address City State Zip

A copy of this form is to be kept on file by the health care professional who performed this clearance.

Return this original, completed form in-person or by mail to:

Creighton Global Engagement Office
Creighton University
2500 California Plaza
Omaha, NE 68178