Student Health Clearance Packet

Health Clearance is required to participate in all Harvard-sponsored international travel (with limited exceptions for travel lasting less than two weeks).

See globalsupport.harvard.edu/travel-tools/forms-policies, or ask your program administrator for more information about this requirement.

Visit globalsupport.harvard.edu/travel-tools/forms-policies for FAQs and additional information.

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Instructions for Students

DEADLINES: Complete the Health Clearance process **30-90 days prior to departure**, or by the date set by your program or funding source. Allow enough time for specialists (if applicable) and Harvard University Health Services (HUHS) to review your forms.

STEP 1: Complete the Confidential Health History Form (pages 2-3), the Student Certification (page 4), and Part 1 of the Health Clearance Form (page 5). **On all pages**, include your name, HUID, destination city and country, travel dates, and funding source (e.g. DRCLAS, OIE, SEAS, etc.).

STEP 2: If you’ve seen mental or physical health specialists in the last year for treatment of a serious, chronic, or ongoing condition, **you must receive clearance from your specialists first** before you can receive health clearance from your primary care physician/HUHS.

- Give your specialists a copy of pages 2-8.
- Ask your specialists to complete Part 3: Specialist Clearance (pages 7-8) **and return it to you**.
- If you’re cleared by your specialists but require medical services or accommodations, you may need to complete the Medical Service and Accommodation Form (page 10).

STEP 3: Deliver a copy of your entire health clearance packet to: Harvard University Health Services ATTN: Medical Records, 6th Floor 75 Mount Auburn Street Cambridge, MA 02138

Your packet should include the completed Confidential Health History Form, the signed Student Certification, and the Health Clearance Form; if applicable, also the completed and signed Specialist Clearance Form(s) and Medical Service and Accommodation Form.

STEP 4: HUHS will review the information provided by you and your specialists (if applicable). **HUHS may require an in-person appointment** in order to make a clearance decision. If so, HUHS will contact you within **five business days** of receiving your packet to schedule an appointment.

STEP 5: If cleared, HUHS will send you a secure message through the Patient Portal. HUHS will then send the Student Certification and signed Health Clearance Form and Specialist Clearance Forms (if applicable) to the Office of International Education (OIE). HUHS will retain the Confidential Health History Form.

If cleared with conditions that require medical services or accommodations, you may need to complete the Medical Service and Accommodation Form (page 10) and submit it to HUHS Medical Records.

**Note:** Your program or sponsor may consult with Harvard officials (i.e. Resident Dean, Administrative Board, or others) about your ability to meet the requirements of your Harvard travel plans. Additionally, if your health status changes after receiving a health clearance but prior to your departure, then you and/or your health provider(s) must contact Harvard immediately. In such circumstances, your health clearance may be reevaluated and may be revoked.

QUESTIONS: Contact Camila Nardozzi, Director, Office of International Education, cnardozzi@fas.harvard.edu
Confidential Health History Form for Harvard-Sponsored International Travel

Completed by student

Last Name: ___________________________ First Name: ___________________________ MI: ______

Preferred Name: ___________________________ HUID: ___________________________ Gender: ______

Email Address: ___________________________ Phone Number: ___________________________

Program and Funding Source: ___________________________

Destination City/ies and Country/ies: ___________________________

Activity (study, research, internship, etc.): ___________________________ Travel Dates: ___________________________

Provide a brief description of the program and its context (including, for example, the remoteness of the location, the availability of medical or other resources, whether the program activities are physically strenuous, and the like):

__________________________________________

List any condition(s) for which you are currently being treated or have been treated by a clinician:

__________________________________________

List any documented physical or learning disabilities:

__________________________________________

Are you currently seeing a physical or mental health specialist for treatment of an ongoing health issue?  Yes [ ]  No [ ]

If yes, for which conditions? ___________________________

Health Specialist Provider’s Name: ___________________________

Phone: ___________________________ Fax: ___________________________

List any other specialists you have seen in the last 12 months and the reason for consultation or treatment:

__________________________________________

Have you ever had surgery? Yes [ ]  No [ ]  If yes, please describe: ___________________________

Do you have drug or food allergies? Yes [ ]  No [ ]  If yes, list the allergy/ies and briefly describe your reaction:

__________________________________________
Medications

Are you currently taking any medications? Yes ☐ No ☐

If yes, please note that you are responsible for ensuring that your medications are legally permissible abroad. Specify the medications you are currently taking, including medication(s) you carry for possible use (e.g. insulin, asthma inhaler, Epi-pen):

____________________________________________________________________________________
____________________________________________________________________________________

Mental Health History

Have you ever suffered from, been treated for, taken medication for, or been hospitalized for the following?

Mental health condition (e.g. depression, anxiety)? Yes ☐ No ☐

If yes, please explain:
____________________________________________________________________________________

Substance abuse (alcohol or drugs)? Yes ☐ No ☐

If yes, please explain:
____________________________________________________________________________________

Eating disorder (e.g. anorexia or bulimia)? Yes ☐ No ☐

If yes, please explain:
____________________________________________________________________________________

Medical Services or Accommodation

Indicate any medical services or accommodation you believe you will need to facilitate participation in your chosen plan for study abroad. Note that Harvard cannot guarantee that medical services or accommodation will be available in the region(s) where you will be living or studying and that, in addition to completing this section, you MUST discuss any requested medical services or accommodations with your program.

____________________________________________________________________________________
____________________________________________________________________________________
Completed by student

Last Name: ___________________________ First Name: ___________________________ MI: ______

Preferred Name: ___________________________ HUID: ___________________________ Gender: ___________________________

Email Address: ___________________________ Phone Number: ___________________________

Program and Funding Source: __________________________________________

Destination City/ies and Country/ies: __________________________________________

Activity (study, research, internship, etc.): ___________________________ Travel Dates: ___________________________

Student Certification

I understand that I may not travel unless I obtain a health clearance, and I certify that all of the information I have provided in the Student Health Clearance Packet is complete, true, and accurate. I understand that if I misrepresent or fail to provide the information requested in the Student Health Clearance Packet, then I may be barred from participation in, dismissed from, or told to discontinue the Harvard travel plans I have chosen. I further understand that if there are any changes in my health status after I have completed the Student Health Clearance process, then I must contact Harvard immediately; I also give permission to my health provider(s) to contact Harvard directly in that circumstance. I understand and agree that health clearances are conditional, meaning that if, between the time I obtain a health clearance and the time of my planned departure, Harvard learns of any changes to my physical or mental health, then my health clearance may be reevaluated and may be revoked.

Student’s Signature: ___________________________ Date: ___________________________
**Part 1: Completed by student**

Last Name: ___________________________  First Name: ___________________________  MI: ______

Preferred Name: ______________________  HUID: ___________________________  Gender: ________________

Email Address: ________________________  Phone Number: ________________________

Program Name (if applicable): _________________________________________________________

Program or Funding Department Requesting Health Clearance: ____________________________

Approximate Dates of Harvard-Sponsored Travel: ________________________________________

Destination City/ies and Country/ies: __________________________________________________

Funding Source(s): ___________________________________________________________________

I hereby authorize my health provider(s) and HUHS to complete this Health Clearance Form. I further authorize my health provider(s) to alert Harvard directly in the event that my health status changes between the time I obtain health clearance and the time of my planned departure. I understand that in such a case my health clearance may be reevaluated and may be revoked.

Student’s Signature: ___________________________  Date: ___________________________

**Note:** Specialist clearance is required if you have been seen by a specialist within the past year. You must complete Part 3 *before* Part 4 can be completed.
Health Clearance for Harvard-Sponsored International Travel

Part 2: Instructions for Specialists and Primary Care Physicians

Specialists and PCPs must be appropriately licensed and credentialed and may not be a family member of the student.

Student: If you’re seeing one or more specialists, or if you’ve seen one or more specialists within the past year, for the treatment of a serious, ongoing, or chronic condition, then you must obtain the approval and signature of each specialist first. Part 2 and Part 3 may be photocopied as needed.

GENERAL REQUIREMENTS OF HARVARD TRAVEL PARTICIPATION

In addition to meeting any specific requirements of the international travel plan or program they have chosen (as set forth in the written description provided by the student on page 2), students must meet the following requirements:

- Possess the physical and mental well-being required to live and 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 their program, including appropriate standards of conduct;
- Be able to display flexibility and to function in the face of potentially uncertain or stressful situations;
- Be able to align their health care needs with the limited resources that may exist nearby;
- Be able to live in a setting different from what they may be accustomed to and that may aggravate existing health conditions (e.g. dormitories that may not be air-conditioned or afford privacy, homestays with local families, etc.);
- Participate in typical classroom work;
- Participate in planned excursions and activities in the area, which may include moderate physical activity.
Part 3: Completed by licensed medical specialist or mental health specialist (may not be a family member of student) and returned to the student

I have thoroughly reviewed the student’s health, referring to the student’s Confidential Health History and Certification, medical records on file, and the general and specific requirements of the student’s international travel plan or program. Based on this information and my current observation of this student, to the best of my knowledge:

CHECK ALL THAT APPLY. AT LEAST ONE (1) BOX MUST BE CHECKED.

Student is CLEARED by specialist

☐ There are no medical contraindications to participation in the international travel plan or program the student has chosen.

☐ There are no mental health contraindications to participation in the international travel plan or program the student has chosen.

Student is CLEARED by specialist provided the following conditions are met:

☐ Student requires medical services or accommodation, as specified below, to facilitate participation in the academic program (e.g. note-taking, wheelchair access). Please note that Harvard cannot guarantee that services or accommodation are available, nor can it guarantee the accessibility of vehicles, housing or other accommodations, study sites, or other places students may visit.

☐ Student requires medical services or accommodation, as specified below, to facilitate a healthy and safe stay abroad (e.g. regularly available psychiatric therapy). Please note that Harvard cannot guarantee that services or accommodation are available.

☐ Student requires medication throughout the duration of the international travel plan or program. Note: It is the student’s responsibility to ensure that the medication is available and legal in their travel destination(s).

☐ Student has a significant allergy to certain medication(s) and/or to certain food(s) and has an appropriate treatment plan in place. Please list allergies:

Continued on next page.
**Student is NOT CLEARED by specialist**

☐ There are *medical contraindications* to participation in the international travel plan or program the student has chosen.

☐ There are *mental health contraindications* to participation in the international travel plan or program the student has chosen.

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**Licensed Specialist**

*May not be a family member of the student*

Name: ________________________________

Title: ________________________________

Specialty: ________________________________

Signature: ________________________________

Date: ___________    Phone: ________________

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*Specialist: Return the completed and signed Part 3 (pages 7-8) to the student.*
Part 4: Completed by Primary Care Physician/HUHS

I have thoroughly reviewed the student’s health, referring to the student’s Confidential Health History, Certification, medical records on file, and the general and specific requirements of the student’s international travel plan or program. Based on this information, to the best of my knowledge:

CHECK ALL THAT APPLY. AT LEAST ONE (1) BOX MUST BE CHECKED.

Student is CLEARED by primary care physician

☐ There are no medical or mental health contraindications to participation in the international travel plan or program the student has chosen.

Student is CLEARED by primary care physician provided the following conditions are met:

☐ Student requires medical services or accommodation, as specified below, to facilitate participation in the academic program (e.g. note-taking, wheelchair access). Please note that Harvard cannot guarantee that services or accommodation are available, nor can it guarantee the accessibility of vehicles, housing or other accommodations, study sites, or other places students may visit.

☐ Student requires medical services or accommodation, as specified below, to facilitate a healthy and safe stay abroad (e.g. regularly available psychiatric therapy). Please note that Harvard cannot guarantee that services or accommodation are available.

☐ Student requires medication throughout the duration of the international travel plan or program. Note: It is the student’s responsibility to ensure that the medication is available and legal in their travel destination.

☐ Student has a significant allergy to certain medication(s) and/or to certain food(s) and has an appropriate treatment plan in place. Please list allergies:

Student is NOT CLEARED by primary care physician

☐ There are medical or mental health contraindications to participation in the international travel plan or program the student has chosen.

Primary Care Clinician (M.D., N.P., or R.N.)

May not be a family member of the student.

Print Name: ____________________________________________
Title: ____________________________________________
Signature: ____________________________________________
Date: ________________________ Phone: ________________

HUHS Provider? Yes ☐ No ☐

If no, date of student’s last physical exam: ________________

Clinician Rubber Stamp
or Business Card Here
Part 5: Completed by Student and the Accessible Education Office

In the space provided below, or on an attached sheet, describe the arrangements you have made to meet the conditions specified in Part 3 and/or Part 4. If you have mobility-related issues, you also must indicate that you have conferred with the leaders of your program (if applicable) and have a feasible plan in place to address any barriers that might exist in and outside your academic, living, and other settings.

Please note that Harvard cannot guarantee that services are available, nor can it guarantee the accessibility of vehicles, housing or other accommodations, study sites, or other places students may visit. However, the Accessible Education Office (AEO) can provide assistance identifying and/or arranging services. Once a plan is established, the AEO must sign in the space below to indicate that the arrangements you have made appear to meet the conditions required for participation in your Harvard travel plan.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I understand that it is my responsibility to make arrangements for the services and/or accommodation that have been identified by the AEO. I understand that if the arrangements described above are amended in any way, then I must inform Harvard immediately.

Student's Signature: ____________________________ Date: ____________________________

Name of AEO staff member ____________________________ Signature of AEO staff member ____________________________