Creighton UNIVERSITY
Global Engagement Office

Creighton UNIVERSITY
Division of Student Life
Student Health Education and Compliance

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 Education & Compliance. 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 2022, Summer 2023)	**NAME OF PROGRAM ABROAD**
COVID-19 VACCINE (**Yes / No** & list date(s) and manufacturer) **COVID-19 BOOSTER** (**Yes / No** & list date(s) and manufacturer)	**Do you have a Creighton University approved medical exemption to the COVID-19 vaccine?** **(Yes / No)**

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	**PRIMARY PHONE NUMBER** **SECONDARY PHONE NUMBER**

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	**PRIMARY PHONE NUMBER** **SECONDARY PHONE NUMBER**

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 CHI Student Care Clinic 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 form to their health care provider for a travel health clearance evaluation.

(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.

When completed, students should upload the completed form (all pages) to the Jays Abroad Portal.

You may also e-mail the completed form to: studyabroadadvisor@creighton.edu

or mail to:

Creighton Global Engagement Office
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2500 California Plaza
Omaha, NE 68178