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 Harvard Summer School for more information about this requirement.

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

Contents

Instructions for Students .................................................................................................................................1

Confidential Health History .........................................................................................................................2-3
Completed by student and given ONLY to health provider(s)
The health history should NOT be provided to Harvard Summer School or to your program.

Certification ....................................................................................................................................................4
Completed by student and submitted to Harvard Summer School with health clearance forms

Health Clearance ...........................................................................................................................................5-10
Completed by student and health provider(s) and returned to student or Harvard Summer School
Instructions for Students

1. The Health Clearance process must be completed by April 2, 2018.

2. Complete the Confidential Health History form (pages 2-3), the Certification (page 4), and Part 1 of the Health Clearance form (page 5). Include the following information on all pages: Name, HUID, destination city and country, travel dates, and funding source, if applicable (e.g. DRCLAS, HSS, OIE, SEAS, etc.).

3. If you have seen mental or physical health specialists in the last year for treatment of a serious, chronic, or ongoing condition, you must receive clearance from these specialists first. They must be given a copy of the Confidential Health History form (pages 2-3) and must complete Part 3 (pages 7-8).

   Note: For students enrolled in another Harvard School, 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.

**HOW TO OBTAIN HEALTH CLEARANCE (TWO METHODS):**

<table>
<thead>
<tr>
<th>PREFERRED: If requesting clearance from Harvard University Health Services (HUHS) (Harvard College students only)</th>
<th>OR</th>
<th>If requesting clearance from a primary care physician (Students from other Schools and Universities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver the Confidential Health History form, the Certification, and the Health Clearance form (including completed specialist clearance forms, if applicable) to: Harvard University Health Services ATTN: Medical Records, 6th Floor 75 Mount Auburn Street Cambridge, MA 02138</td>
<td></td>
<td>Send the Health History form, Health Clearance form (including specialist clearance if required), and Harvard travel plan description to your doctor’s office.</td>
</tr>
<tr>
<td>Upon review of the information provided, HUHS may require an in-person appointment in order to make a clearance decision. If so, you will be contacted within 5 business days of submitting your packet to schedule an appointment.</td>
<td>Your doctor completing this form cannot be a family member.</td>
<td>Upon review of the information provided, your primary care physician may, but is not required to, schedule an appointment with you.</td>
</tr>
<tr>
<td>HUHS will send you an email confirmation and send the Certification, along with the original signed medical and mental health clearance form(s) to Harvard Summer School.</td>
<td></td>
<td>Either you or your primary care physician must send the Certification and the original signed medical and mental health clearance form(s) to: Harvard Summer School Study Abroad Programs 51 Brattle Street Cambridge, MA 02138</td>
</tr>
<tr>
<td>The Confidential Health History Form (pages 2-3) will NOT be sent to Harvard Summer School.</td>
<td></td>
<td>The Confidential Health History Form (pages 2-3) should NOT be sent to Harvard Summer School.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We cannot accept electronic copies or faxes.</td>
</tr>
</tbody>
</table>

**QUESTIONS?**

Contact Harvard Summer School Study Abroad Programs, summerabroad@dce.harvard.edu.
Confidential Health History  
for Harvard-Sponsored International Travel

To be completed by student and retained by student’s health care provider

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 the Harvard Summer School Accessibility Services Office.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
To be completed by student and submitted to Harvard

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: ______________

Certification

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 there are any changes in my health status, I will contact Harvard immediately. 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.

Student’s Signature: ____________________________________________  Date: ________________
Part 1: To be 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): ________________________________________________________

**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 Health Providers

Health providers must be appropriately licensed and credentialed and may not be a family member of the student they are evaluating.

1. Review the following:
   - General requirements of the Harvard Travel Participation, set forth below
   - Completed Harvard University Confidential Health History (pages 2-3) and Student Certification (page 4)

2. Complete the Health Clearance:
   - Physical or Mental Health Specialists: Complete Part 3 of the Health Clearance on pages 7-8.
   - Primary Care Physicians: Verify that medical or mental health specialists have completed Part 3 of the Health Clearance (if required), and then complete Part 4 on page 9.

3. Submit ONLY the Student Certification form (page 4) and medical and mental health clearance forms (pages 7-9) to:
   Harvard Summer School Study Abroad Programs
   51 Brattle Street
   Cambridge, MA 02138

The Confidential Health History Form (pages 2-3) must NOT be sent to Harvard Summer School.

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), 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: If applicable, to be completed by licensed medical or mental health specialist (may not be a family member of student) and submitted to Harvard

If the student is seeing one or more specialists, or has seen one or more specialists within the past year, for the treatment of a serious, ongoing, or chronic condition, then the approval and signature of each specialist must be obtained before final clearance is signed by a Primary Care Clinician. If this section does not apply, please skip to the next section. This section may be photocopied as needed.

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.

**Licensed Specialist**

*May not be a family member of the student*

Name: ____________________________________________

Title: ____________________________________________

Specialty: ________________________________________

Signature: ________________________________________

Date: ________________    Phone: ___________________

Licensed Specialist Rubber Stamp
or Business Card Here
Part 4: To be completed by primary care physician (may not be family member of student) and submitted to Harvard

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, 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
To be completed by Student and the Harvard Summer School Accessibility Services Office

Complete this page only if one of your health providers indicated that medical services or accommodation were required to facilitate your participation in your planned academic program or to facilitate a healthy and safe study abroad.

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 Harvard Summer School Accessibility Services Office can provide assistance identifying and/or arranging services. Once a plan is established, the Harvard Summer School Accessibility Services Office 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.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand that it is my responsibility to make arrangements for the services and/or accommodation that have been identified by the Harvard Summer School Accessibility Services Office. 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 Harvard Summer School
Accessibility Services Coordinator

Signature of Harvard Summer School
Accessibility Services Coordinator