



HARVARD SUMMER SCHOOL

Harvard Summer School Study Abroad Programs 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 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

- The Health Clearance process must be completed **by April 12, 2022**.
- 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. HSS, OIE, DRCLAS, SEAS, etc.).
- Print the International SOS medical report for your destination country (provided by [Harvard Summer School](#), and also available from the [International SOS member portal](#)), and attach it to your Health Clearance form.
- If you have seen mental or physical health specialists in the last year, **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).
- If your health status changes after receiving a health clearance but prior to your departure, then you and/or your health provider must contact Harvard immediately. In such circumstances, your health clearance may be reevaluated and may be revoked. 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.
- **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. 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.

HOW TO OBTAIN HEALTH CLEARANCE (TWO METHODS):

PREFERRED: If requesting clearance from Harvard University Health Services (HUHS) (Harvard College students only)	OR	If requesting clearance from a primary care physician (Students from other Schools and Universities)
<p>Deliver the Confidential Health History form, the Certification, the Health Clearance form (including completed specialist clearance forms, if applicable), and the International SOS country medical report to:</p> <p style="padding-left: 40px;">Harvard University Health Services ATTN: Medical Records, 6th Floor 75 Mount Auburn Street Cambridge, MA 02138</p> <p>We cannot accept electronic copies or faxes.</p>		<p>Send the Health History form, Health Clearance form (including specialist clearance if required), Harvard travel plan description, and the International SOS country medical report to your doctor's office.</p> <p>Your doctor completing this form cannot be a family member.</p>
<p>Upon review of the information provided, HUHS may require an in-person appointment to make a clearance decision. If so, you will be contacted within 5 business days of submitting your packet to schedule an appointment.</p>		<p>Upon review of the information provided, your primary care physician may, but is not required to, schedule an appointment with you.</p>
<p>HUHS will send you an email confirmation and send the Certification, along with the <i>original</i> signed medical and mental health clearance form(s) to Harvard Summer School.</p> <p>The Confidential Health History Form (pages 2-3) will NOT be sent to Harvard Summer School.</p>		<p>Either you or your primary care physician must send the Certification and the <i>original</i> signed medical and mental health clearance form(s) to:</p> <p style="padding-left: 40px;">Harvard Summer School Study Abroad Programs 51 Brattle Street Cambridge, MA 02138</p> <p>The Confidential Health History Form (pages 2-3) should NOT be sent to Harvard Summer School.</p> <p>We cannot accept electronic copies or faxes.</p>

QUESTIONS? Contact Harvard Summer School Study Abroad Programs, summerabroad@summer.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:

Student Name: _____ HUID: _____ Travel Dates: _____
Destination City, Country: _____ Sponsor/Funding Source(s): _____

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.*

Student Certification of Health Information

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 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 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: _____

Health Clearance for Harvard-Sponsored International Travel

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): _____

I hereby authorize my health provider to complete this Health Clearance Form and submit it to Harvard. I further authorize my health provider 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, and 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 Health Providers

*Health providers must be appropriately licensed and credentialed and **may not be a family member** of the student they're 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)
- International SOS medical report for the destination country (attached)

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.

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

Note: If, prior to the student's planned departure, there are changes to the health status of a student who has been CLEARED to travel, then the health provider must alert Harvard and may be required to reevaluate whether the student remains CLEARED to participate in the travel plan or program.

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.

Student Name: _____ HUID: _____ Travel Dates: _____
 Destination City, Country: _____ Sponsor/Funding Source(s): _____

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, 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 Name: _____ HUID: _____ Travel Dates: _____
 Destination City, Country: _____ Sponsor/Funding Source(s): _____

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*

Student Name: _____ HUID: _____ Travel Dates: _____
 Destination City, Country: _____ Sponsor/Funding Source(s): _____

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*

Student Name: _____ HUID: _____ Travel Dates: _____
 Destination City, Country: _____ Sponsor/Funding Source(s): _____

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.

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