UNIVERSITY OF NEBRASKA AT OMAHA
EDUCATION ABROAD

HEALTH FORM

This form must be completed in order to participate in education abroad programming (both international and domestic) for which you will receive UNO sponsorship or credit. Complete the sections on pages 1 - 4, then arrange an appointment with your health provider. Bring this form to your appointment and discuss the contents together so that you can receive guidance that will help you prepare for your upcoming travel. Incomplete forms will not be accepted. You must inform UNO Education Abroad about any recent medical or special needs or changes in health that occur after your health clearance appointment but before the start of the program. The information you provide is confidential. Completed forms will be reviewed by UNO Education Abroad. For participants of Global Courses, a copy of this form may be provided to the program leader/on-site coordinator so that they can better assist you in the event of an emergency.

Part of this review includes your immunizations record. Students can access the immunization record that they submitted during their admission process to UNO in their MavLINK account. This may not reflect all immunizations received or be the most up to date record, in which case students should contact their doctor for their complete and current record.

The participant must take this form to their health care provider for a travel health clearance evaluation. When completed, all 6 pages should be uploaded by the participant to the Forms section in Via-TRM.

THE FOLLOWING IS TO BE REVIEWED AND SIGNED BY A MEDICAL PROVIDER AND SUBMITTED TO UNO EDUCATION ABROAD NO EARLIER THAN 6 MONTHS AND NO LATER THAN 2 MONTHS PRIOR TO DEPARTURE.

SECTION 1: STUDENT INFORMATION	
NAME (FIRST, LAST):	NUID:
DATE OF BIRTH:	GENDER:
NAME OF PROGRAM:	TERM ABROAD/AWAY:
DIETARY RESTRICTIONS: (vegetarian, vegan, halal, kosher, etc.)	

SECTION 2: PERSON TO NOTIFY IN CASE OF EMERGENCY	
NAME OF CONTACT (FIRST, LAST):	RELATIONSHIP:
STREET ADDRESS:	CITY, STATE, ZIP:
EMAIL:	PRIMARY PHONE NUMBER:

SECTION 3: COUNTRIES AND ACTIVITIES	
COUNTRY/COUNTRIES TO BE VISITED:	
DATES OF TRAVEL:	
WILL YOU BE:	**YES/NO**
ASCENDING TO HIGH ALTITUDES (>7000 FT or 2,300 METERS):	
WORKING WITH EXPOSURE TO ANIMALS:	
SPENDING EXTENDED TIME IN POOR AIR QUALITY:	
WALKING EXTENSIVELY OR AS A PRIMARY FORM OF TRANSPORTATION:	

SECTION 4: PHYSICAL OR PSYCHOLOGICAL ACCOMMODATIONS

Reasonable accommodations are provided for students in the study abroad/away program who register with the Accessibility Services Center (ASC) and make their requests sufficiently in advance. Please make an appointment with the Accessibility Services Center well in advance (i.e. 3 months of the start of the study abroad program) to ensure coordination of services can occur between the student, ASC and the Education Abroad Advisor. Accommodations may not be possible on all programs and locations. For more information, contact Accessibility Services Center, Location: H&K 104, Phone: 402.554.2872, Email: unoaccessibility@unomaha.edu.

Please describe any physical or psychological conditions that may impact your ability to participate in the travel program. Include any dietary restrictions or need for accessible transportation and housing. Consider that travel can impose extraordinary and sometimes unpredictable psychological and physical demands on you for which you should be as prepared as possible beforehand.

CONDITION	ACCOMMODATIONS OR SUPPORT NEEDED

SECTION 5: 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 brought along or accessible on-site.

MEDICATION	REASON FOR USE	FREQUENCY OF USE

SECTION 6: DRUG/FOOD/ENVIRONMENTAL ALLERGIES AND CONDITIONS

List all drug, food, and environmental allergies and briefly describe the reaction.

ALLERGEN	DESCRIBE REACTION

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		

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

HEALTH CONDITION	YES/NO	IF YES, EXPLAIN
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		
Anxiety/panic attacks		
Bipolar disorder		
Depression		
Eating disorder		
Schizophrenia		
Substance abuse (alcohol or drugs)		
Other mental health conditions (list):		

IMMUNIZATION RECORDS	MOST RECENT DATE
POLIO	
TDAP	
MMR	
COVID 19	

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 UNO Education Abroad 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 education abroad program I have chosen. I authorize the UNO Education Abroad Office to share this information with my program leader/coordinators, the travel program sponsor or host institution, and the health provider at the travel destination, unless I notify the UNO Education Abroad Office in writing.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

I hereby authorize representatives of University of Nebraska at Omaha 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 University of Nebraska at Omaha 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: _____

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HEALTH PROVIDER INSTRUCTIONS:

- Please read the Health Clearance Instructions.
- Review the participant's health and discuss it thoroughly with them, 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 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 on page 6)

Initial	Participant is NOT CLEARED. There are medical or mental health contraindications to participation in the travel 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 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 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 program and prescriptions have been provided to support the necessary medication.
Please list medications: _____

_____

_____

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

_____

Participant has been advised to receive the following immunizations. Please list:

_____

_____

_____ _____

Licensed Physician / Health Provider* (Please print legibly) License Number

_____ _____

Signature of Health Provider Date

_____ _____

Phone Email (if applicable)

_____

Name of Clinic and Address

*Physician or Health Provider must be licensed in the U.S. & cannot be an immediate family member of participant. (See AMA Code of Ethics E-8, 19).

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