University of Vermont | Office of International Education

St. Lucia – Community Development

Medium Medical Risk Destination

MEDICAL CLEARANCE FORM

The University of Vermont (UVM) requires that you receive clearance for participation from your medical provider (a professional who has a good understanding of your medical and/or psychiatric conditions - ex: home primary care physician or student health services provider).

Mild, pre-existing health conditions can become more serious under the stresses of a new, unfamiliar environment, such as what you will encounter during your experience abroad, and health care availability varies across the world. Certain health conditions may not be able to be accommodated in some program destinations given this variability, and it is critical that both you and the University make informed decisions about your participation.

Instructions to student

- Give your medical and/or mental health provider(s) a copy of this form. This individual should be well-acquainted with your medical history.
- A certified medical provider must complete the designated section below.
- Upload a signed copy of both pages of this form to your GoAbroad account before the deadline.
- Recommended: share a copy with your emergency contacts and mental health provider (if applicable).

UVM has contracted with an International Travel Assistance provider to provide worldwide assistance and evacuation services in emergencies for UVM students participating in travel study or study abroad activities. The provider also offers travel, medical, and security advice and services, basic international health insurance, as well as online access to information. **This coverage is valid in territories of the U.S. and countries outside of the U.S., provided that the location is not considered your home.**

(This section to be completed by the student)

Permission to release information to the University of Vermont:

I, _____(student name), hereby authorize _____ (Health Care Provider), to provide full information requested on this form and based on Health Care Provider's knowledge of medical conditions I may have. This information will be provided to and will be relied on by University of Vermont personnel to authorize and provide reasonable accommodations when deemed appropriate for my participation in a study abroad program.

Name: (please print) _____ Date: _____

Signature: _____ Phone: _____

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Instructions to the Participant's Health Care Provider

Please evaluate this individual's health, taking into account that living and studying in a new, unfamiliar environment frequently triggers unexpected stress, which can exacerbate or re-trigger physical or mental health conditions. The participant must be able to adjust to potentially dramatic changes in climate, diet, living arrangements, social life, and study. The student may additionally be exposed to environmental/social conditions that may reflect different values and social priorities. Moreover, medical care may be difficult to obtain and/or less reliable in the program's destination.

This individual will participate in a program of study in St. Lucia. UVM's International Travel Assistance provider has assigned to this destination the following medical risk rating: ***Medium Risk:*** Countries where quality medical care is generally available from selected providers. Reliable emergency services, limited specialist and dental care are usually available. Some risk of food or water-borne diseases. Potentially life-threatening infectious diseases such as malaria and typhoid may be present. In St. Lucia, medical care is limited, and does not consistently meet international standards. Serious medical problems will require air evacuation to a location with a higher level of care.

Physical demands and related health issues for this program: *None*

Certifying Health Care Provider (please print):

Name: _____Credentials:_____

Address: _____

City: _____ State:_____ Zip Code: _____

License/Certification number and state of licensure:_____

Date of initial contact with student: _____ Date of last contact with student: _____

On the basis of my knowledge of this student's mental and physical health, the destination's medical risk rating and the program itinerary, **(please check only one):**

☐ I find no medical or psychological contraindications to this student's participation in this program.

☐ I recommend against this student's participation in this program.

☐ I support this student's participation in this program, but only under the following conditions:

_____

_____

I have discussed my response above with the participant, have provided appropriate counseling and care instructions, and am returning the form to the student.

Signature: _____ Date: _____