Mental Health Clearance for Study
Skidmore Programs Abroad

Student Name: ____________________________________________

Skidmore Abroad Program in: ________________________________

Program Date: ____________________________________________

☐ I, the above student, have not received mental health care or services in the past. (Please sign below.)

Student Signature: ________________________________________ Date: ________________

☐ I, the above student, have received mental health care or services in the past.

Check appropriate box:

☐ The above student has received mental health care from me since ______________ (date).

☐ At this time there is no apparent mental health contraindication to participating in the study abroad program.

☐ If student is taking psychiatric medication, the plan for obtaining it while abroad is as follows:
____________________________________________________________________________________

☐ I have suggested that s/he contact the Skidmore Program Abroad Resident Director of her/his program to discuss any anticipated needs for support while abroad. Comments:
____________________________________________________________________________________

☐ I have concerns regarding the student’s ability to participate in the study abroad program. Comments:
____________________________________________________________________________________

Clinician name (print): ____________________________________________

Signature: _____________________________________________________

Phone number: ________________________ Date: ____________________

I, ________________________________, an applicant for the Skidmore Programs Abroad, give permission to my mental health provider completing this form to release the required mental health information to Skidmore College Health Service, the Skidmore Programs Abroad office and to the Resident Director of the Skidmore Program Abroad in _______________________________.

Student Signature: ______________________________________ Date: ________________