Mental Health Consultation Report
Prior to Tufts Programs Abroad Attendance

Student Name: _______________________________________________________

Tufts Abroad Program in: ____________________________________________

Program Date: _____________________________________________________

I met with this student on _________________________ (Date of Appointment).

According to our records the student received mental health care from __________________ (Provider Name) on ____________________ (Date) to ____________________ (Date).

Comment: _____________________________________________________________________________

Check appropriate box:

 Based on what the student shared with me during the interview, there is no apparent mental health contraindication to participating in the study abroad program.

Comment: _____________________________________________________________________________

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

___________________________________________________________________________________

___________________________________________________________________________________

 I have suggested that they contact the Tufts Program Abroad Resident Director of their program to discuss any anticipated needs for support while abroad.

Comment: _____________________________________________________________________________

___________________________________________________________________________________

 I have concerns regarding the student’s ability to participate in the study abroad program.

Comment: _____________________________________________________________________________

___________________________________________________________________________________

Clinician name (print): ________________________________________________

Signature: _____________________________________________________________

Phone number: __________________________ Date: __________________________

I, ______________________________________, an applicant for the Tufts Programs Abroad, give permission to my mental health provider completing this form to release the required information above to the Tufts Programs Abroad office and to the Resident Director of the Tufts Program Abroad in ________________________________.

Student Signature: ________________________________________________ Date: __________________________

Please return this form to: Tufts University Health Service, 124 Professors Row, Medford, MA 02155
Fax: 617-627-3592

*Please Return Form to Health Service before 15-December for Spring semester abroad and 15-June for Fall semester abroad*