

# MEDICAL CLEARANCE FORM



## To the Physician

We prefer that this form is completed by a physician, physician assistant or nurse practitioner who has been involved with the applicant's ongoing, comprehensive care. When this is not possible, the form may be completed at a campus health center or by a physician, physician assistant, or nurse practitioner who is not part of your primary physician's practice. Information disclosed in this form will be kept confidential. Print clearly.

## Applicant Information

Date of exam

Applicant's Full Name

Length of time applicant has been your patient

## General Information

Significant Medical / Psychiatric History

Past Hospitalizations (include surgeries)

Diagnosis/Treatment of alcohol addiction?  Yes  No

Diagnosis/Treatment of drug addiction?  Yes  No

If yes to either of the above, please explain

# MEDICAL CLEARANCE FORM continued

## Family History

[Redacted]

## Current Medications (prescribed & over-the-counter)

[Redacted]

## Allergies to medications, food, or other

[Redacted]

Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount	[Redacted]
Alcohol use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount	[Redacted]

## Immunizations

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Influenza Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria / Tetanus Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria / Tetanus / Pertussis Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B Series Completed	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A Series Completed	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Measles / Mumps / Rubella Vaccine	Immunity Confirmed	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Menningitis Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Polio Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Varicella / Zoster Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	Pnuemonia Vaccine	Date of last dose	[Redacted]
<input type="checkbox"/>	<input type="checkbox"/>	TB Skin Test	Last test date	[Redacted] Results <input type="checkbox"/> Pos <input type="checkbox"/> Neg
<input type="checkbox"/>	<input type="checkbox"/>	History of positive TB test	Date of last dose	[Redacted]

Other Vaccines [Redacted]

Please discuss with this patient any additional vaccine or prophylactic treatment recommendations you may have based upon their region of travel.

# MEDICAL CLEARANCE FORM continued

## Physical Exam

BP  /  Pulse  / min Temperature

Check the box if normal, otherwise describe:

- HEENT
- Oral / Teeth
- Heart
- Lungs
- Stomach / Abdomen
- Genitourinary
- Extremities / Joints / Muscles / Spine
- Skin / Lymph Nodes
- Neurologic

## Assessment

Do you have any concern regarding this applicant's participation in a Sharing The Journey International mission program?

## Physician Information

Name (Please print)

Signature

Office Address

City  State  Zip