

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

Current Medications (prescribed & over-the-counter)

Allergies to medications, food, or other

Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount	<input type="text"/>
Alcohol use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount	<input type="text"/>

Immunizations

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Influenza Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diptheria / Tetanus Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diptheria / Tetanus / Pertussis Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B Series Completed	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A Series Completed	Date of last dose	<input type="text"/>
<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"/>	Meningitis Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Polio Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Varicella / Zoster Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pnuemonia Vaccine	Date of last dose	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	TB Skin Test	Last test date	<input type="text"/> Results <input type="checkbox"/> Pos <input type="checkbox"/> Neg
<input type="checkbox"/>	<input type="checkbox"/>	History of positive TB test	Date of last dose	<input type="text"/>

Other Vaccines

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