

Medical Clearance



Please submit via mail to:

Hands Together)

Mail: P.O. Box 80985, Springfield, MA 01138

Fax: 413.731.6405

email: handstog@gmail.com

To the Physician:

If possible, this form should be completed by a Physician or P.A. who knows the applicant's ongoing, comprehensive health care and history. This form will be used to assess the applicant's fitness for service in Haiti. The information disclosed in this form will be kept confidential. Type or print clearly.

Applicant Information

APPLICANT'S NAME

DATE OF EXAM

LENGTH OF TIME APPLICANT HAS BEEN YOUR PATIENT

General Information

SIGNIFICANT MEDICAL HISTORY

PAST HOSPITALIZATIONS

Diagnosis/treatment of alcohol addiction yes no
If yes, please explain:

Diagnosis/treatment of drug addiction yes No

FAMILY HISTORY -SIGNIFICANT MEDICAL/PHTYSCHIATRIC

MEDICINES - REASONS FOR PRESCRIBING

SIGNIFICANT PRESENT MEDICAL PROBLEMS

ALLERGIES - DIETARY RESTRICTIONS

TABACCO/ALCOHOL USES

MMUNIZATIONS UP TO DATE?

General Physical Information

WT. HT. BP. P.

LAB IF DONE RECENTLY U/A CXR CBC BASIC CHEMISTRY PANEL

Do you have any medical concern about this applicant participating in the Hands Together Volunteer program in Haiti?

Physician Information

PHYSICIAN'S NAME SIGNATURE

ADDRESS

CITY CITY ZIP

PHONE EMAIL ADDRESS