Global Education Initiatives
Medical Clearance Form

Section I: Applicant Medical History and Certification

A. Please describe your overall physical and mental health:

B. Are you currently under the care of a doctor? If "yes," please specify the reason.

C. While abroad, will you require any medication (e.g. for allergies, diabetes, epilepsy, etc.) on a regular or periodic basis? If "yes," please be specific and list below the chemical composition, not the name brand.

D. Instructions: Please put the following questions about your past or present medical history with a YES or NO. If you are not sure, answer YES. If any of these items apply to you, please discuss them with your physician**. An affirmative response does not necessarily disqualify you from participation in the Semester of Service Program. Your answers will remain confidential.**

Have you ever had or do you currently have ….

____ Asthma?

____ Allergies?

____ Any form of lung disease or injury?

____ Epilepsy, seizures, or convulsions?

____ History of fainting or blackouts?

____ Anxiety, mania or clinical depression?

____ History of cancer?

____ Impaired hearing or vision?

____ History of bleeding or blood disorders?

____ History of back problems or surgery?

____ Diabetes?

____ Inability to perform moderate exercise?

____ High blood pressure

____ History of heart disease or arrhythmia?

____ Other mental health conditions?

____ HIV/AIDS or other immune deficiency?

____ Nervous system or neurological illness?

____ History of drug or alcohol abuse?

If you have answered YES to any of the above, please provide details describing your medical condition or history below. **Please include information on any other medical condition not listed above that may apply to you**:

E. Emergency Contact: Please provide contact information for a family member or friend who you authorize America's Unofficial Ambassadors to share information with regarding your medical condition and status in the event of an emergency.

Name:

Relationship to you:

Phone:

Email Address:

I hereby certify that America's Unofficial Ambassadors and its representatives are authorized to share information regarding my medical condition with (Name of Contact) ________________________ in the event of an emergency.

Signature:

Date:

F. Certification:
The information I have provided above about my medical history is accurate to the best of my knowledge.

Signature:

Date:

II. Physician's Examination (This section must be completed by a medical doctor.)
A. Instructions: This person is an applicant for the America's Unofficial Ambassadors Semester of Service program. The program involves volunteer service in a developing country that, in some places, may have limited resources for medical care. Your opinion of the applicant's medical fitness is requested.

	Normal	Requires Treatment
Cardiovascular system	___	___
Current mental status	___	___
Central nervous system	___	___
Abdomen	___	___
Respiratory system	___	___
Hearing	___	___
Vision	___	___

B. Please describe any findings that require treatment or other medical attention:

C. Contact Information
Are you the applicant's regular doctor? Yes___ No___

Doctor's Name: Medical Center:

Town/City: Phone:

Email:

D. Physician's Impression:
___ Satisfactory: Applicant can be accepted
___ Not satisfactory: Applicant should not be accepted

E. Vaccinations and Malaria Medication: Program participants are required to show proof that they have obtained the following vaccinations prior to departure for their country of service. In addition, volunteers for the Indonesia program must obtain medications to safeguard them against malaria.

Please attach to this document a copy of all vaccination cards and note below vaccinations administered to the applicant or received previously for the following conditions:

1. Measles, Mumps and Rubella (MMR) ____

2. Diphtheria, Pertussis and Tetanus (DPT) ____

3. Polio ____

4. Typhoid ____

5. Rabies ____

6. Hepatitis A and B ____

F. Additional Notes (if applicable)

Signature:

Date: