



PHYSICIAN'S REPORT AND EXAMINATION

PLEASE COMPLETE & RETURN AS SOON AS POSSIBLE TO:
 Global Works ♦ 1113 South Allen Street ♦ State College, PA 16801

Participants Name _____

Country in which participant will be traveling: _____ Program Dates: _____

I have examined (participant's name) _____ within the past year and in my opinion, the above's condition (check one) ? DOES NOT / ? DOES preclude his/her participation in an active travel program.

Physician's Signature _____

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria	1.	1.
Pertusis DPT*-----	2.	2.
Tetanus	3.	3.
or		
Tetanus		
Diphtheria TD*-----	--	--
or		
Tetanus----- Oral	--	--
Polio (Sabin)*-----	--	--
Injectable Polio (Salk) -----	--	--
Measles (hard measles, red measles, Mumps) -----	--	--
Rubella (Gr. measles, 3 day measles, Other)-----	--	--
Tuberculin test given _____		
Haemophilus influenza b (HIB) -----	--	--
Hepatitis A -----	--	--

1. Applicant's Height _____ Weight _____

2. Known allergies. (including medication allergies, food allergies, or other)

Type	Describe reaction and management of reaction

3. Medications to be administered during the program.

Medication	Taken For (Condition/Symptom)	Dosage (Size/Frequency)	Date Started	Current Side Effects (if any)

4. Are changes in activity level, daily schedule, fluid intake, diet, or external temperature or altitude likely to disrupt the effectiveness of the medications?
? NO / ? YES If yes, please describe.

5. If medication(s) were lost and couldn't be replaced in less than 1-3 days would this be problematic?
? NO / ? YES If yes, please describe.

6. Does your patient experience any side effects including dizziness, dehydration, sun sensitivity, or stomach sensitivity?
? NO / ? YES If yes, please describe.

7. Patient is under the care of a physician for the following condition(s):

8. Treatment(s) to be continued during the program.

9. Any medically prescribed dietary restrictions?

10. Explanation of any reported loss of consciousness, convulsion or concussion:

11. Description of any limitation(s) or restriction(s) on program activities.

12. Please provide any additional information (below or on a separate attached sheet) about the participant's physical, emotional, or mental health about which the program staff should be aware.

Licensed Physician's <i>PRINTED</i> name _____
Phone # (_____) _____
Address _____

Date Form Completed _____ *By _____