

## MARION MEDICAL MISSION 2010 HEALTH FORM

This form must be completed by BOTH you AND your physician. After the physician has signed this form, please sign the lower portion certifying that you have had or will have the immunizations and medications listed and those required/recommended by the Center for Disease Control. Then promptly return this form to Marion Medical Mission. **It may take a few months to complete immunizations—start immediately after acceptance for the mission trip.**

PARTICIPANT/PATIENT NAME (Please print)

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This section must be completed by your **PRIMARY CARE PROVIDER**:

**PRIMARY CARE PROVIDERS/CLINICIANS: IMPORTANT, PLEASE READ:** Travel to Africa, can be difficult, both physically and emotionally. Please know that travel will be long and tiring; vehicles will primarily be 4-wheel drive trucks on very rough roads, paths and many times off road. Well sites are reached by walking, often long distances, sometimes uphill. During that time of year, weather will be hot - mid-80s to 100 degrees, sometimes very humid, often breezy with dust and wood smoke in the air. Health care resources are often a long distance away and inadequate. Please be sure the patient is in good physical shape for this trip.

The Marion Medical Mission leadership team should be aware of the following medical or emotional conditions or physical limitations of this patient:

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This patient has the following allergies (include any medications to which this patient is allergic.)

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List **ALL MEDICATIONS** this patient is taking (including dose and frequency of administration).

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I have examined this patient and (please check one)

found her/him in general good health and able to withstand the travels and lifestyle this trip will involve (as noted above).

do NOT recommend her/him for participation in this trip due to: \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Print/Type/Stamp Physician's Name \_\_\_\_\_

Clinic Name (Please print) \_\_\_\_\_

Clinic Office Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

The following section must be completed by **PARTICIPANT/PATIENT**:

I understand that the following immunizations and medications are recommended by the Center for Disease Control for the area and conditions of this project and **are required** by Marion Medical Mission. I also understand that this original form must be returned to Marion Medical Mission. By signing below, I certify that those immunizations and medications have **either been completed or have been started and will be completed prior to September 17, 2010.**

TETANUS AND DIPHTHERIA,  MALARIA TABLETS,  TYPHOID,  HEPATITIS A,  YELLOW FEVER,  POLIO,  MENINGITIS,  PNEUMONIA\*\*,  INFLUENZA\*\*,  HEPATITIS B and I WILL DISCUSS/HAVE DISCUSSED TRAVELER'S DIARRHEA with my physician.

\*\*Required for age 65 and above.

Signature \_\_\_\_\_ (Printed Name) \_\_\_\_\_ Date \_\_\_\_\_