Engineering World Health

Summer/Winter Institute

Medical Examination Form

Notes to the Examining Physician

(I) The new and strenuous environment encountered during the Summer/Winter Institute will tax each participant's physical and mental capabilities to the fullest. It is, therefore, imperative, as a safeguard to the health of the participant, that this report be as complete and precise as possible.

(II) Participants will be working in temperatures ranging from 40 to 110 degrees Fahrenheit (4 to 43 Celsius).

(III) The physician should also bear in mind that medical facilities available for participants will only cover acute illness and accidents. There are no facilities available within this framework for the treatment of chronic disturbances. Dental treatment and eyeglasses are not included and will be arranged at the participant's expense.

(IV) Any applicant who has been under the care of a specialist must submit a written detailed report from such specialist giving complete diagnosis, prognosis and evaluation. The World Health Organization recommends caution when traveling to the developing world if a person suffer from cardiovascular disorders, chronic hepatitis, chronic inflammatory bowel disorders, chronic renal disease requiring dialysis, chronic respiratory diseases, diabetes mellitus, epilepsy, immunosuppression due to medication or HIV, previous thromboemolic disease, severe anemia, severe mental disorders or any chronic condition requiring frequent medical intervention. If the applicant suffers from any of these conditions, please discuss the condition(s) and developing world travel with your patient.

If an applicant is required to continue therapy or treatment, or to continue receiving medicines and drugs while under the auspices of the program, he/she should have a medical letter giving full details. Often medicine is not available under the same trade name as in the country of origin, therefore, the full pharmacological name of all medicines and drugs must be provided on this form, and a failure to submit such a letter shall result in expulsion of the applicant from the EWH Summer/Winter Institute without any refund.

If any changes take place in the applicant's condition within the last 10 days before departure, the applicant must submit, before departure, a full, explanatory medical letter, detailing diagnosis, prognosis, and treatment. Failure to submit such a letter shall result in expulsion of the applicant from the EWH Summer/Winter Institute without any refund.

(V) EWH intends to rely on this completed form and supplementary letters in making determinations of acceptance for or continuation of the applicant in the program. Omissions or mis-statements are at the risk of the applicant and the physician, surgeon, psychiatrist, psychologist, or social worker.

(VI) The information on this report form and all supplementary letters and reports on the physical, mental or psychological condition of the applicant shall be held by EWH as strictly confidential.

(VII) Malaria is a potentially life-threatening disease prevalent in parts of the developing world. Malaria can be prevented with a prophylaxis. The decision to take or not take malaria prophylaxis is an individual decision that should be discussed with a qualified physician. EWH is not responsible in any way for a participant's decision regarding malaria prophylaxis or that decision's consequences.

(VIII) The air quality of the applicant's destination should be considered. Large cities of some developing nations, for example, Kathmandu in Nepal, have high levels of pollution. This may cause problems for participants with asthma, allergies, or other respiratory concerns.

(IX) **SHOULD ANY PARTICIPANT UPON ARRIVAL, OR DURING THE EWH SUMMER/WINTER INSTITUTE, BE FOUND TO BE SUFFERING FROM ANY CONDITION, MENTAL OR PHYSICAL, THAT IS NOT FULLY DISCLOSED IN THIS MEDICAL FORM OR IN AN ATTACHED PSYCHOLOGICAL PROFILE THEN, (1) HE OR SHE MAY, AT THE SOLE AND ABSOLUTE DISCRETION OF EWH OR ITS REPRESENTATIVES, BE RETURNED TO THE PLACE OF ORIGIN AT THE PARTICIPANT'S OWN EXPENSE, OR MAY BE TREATED, AT THE PARTICIPANT'S OWN EXPENSE, AND THERE SHALL BE NO REFUND OF MONEYS PAID FOR THE EWH SUMMER/WINTER INSTITUTE, AND (2) EWH AND ITS REPRESENTATIVES ARE THEREBY RELEASED OF ALL RESPONSIBILITY OR LIABILITY OF ANY KIND WHATEVER ARISING OUT OF ANY ASPECT OF SUCH PARTICIPANT'S MEDICAL HISTORY AND MENTAL OR PHYSICAL CONDITION.**

PERSONAL HEALTH HISTORY: To Be Completed by Applicant

This information is essential to enable us to fully address the needs of individual participants throughout the program. Applicants to Engineering World Health Summer/Winter Institute should know that contact with social workers, psychologists, or psychiatrists in no way disqualifies an individual from participation in our programs. We appreciate and expect, therefore, that individuals will fully disclose any relevant records of his or her mental health.

NAME & ADDRESS (Participant & Parent or Guardian)

Last Name First Name Birth date Sex

Number & Street

City State/Territory Zip Country

Parent or Guardian (_____) Parent/Guardian Home Phone

Number & Street (_____) Parent/Guardian Office Phone

City State/Territory Zip Country (_____)_____ Parent/Guardian Cell Phone

IMPORTANT: If parent is not available in case of emergency notify:

Name Relationship to Participant

Number & Street (_____) Home Phone

City State/Territory Zip Country (_____)_____ Cell Phone

(_____)_____ Office Phone

HEALTH HISTORY (Check "Yes" or "No" and give dates for all "Yes" answers)

	Y	N	Date		Y	N	Date		Y	N	Date
Asthma				Eye Trouble				Pneumonia			
Bronchitis				Fainting				Poliomyelitis			
Cancer				Frequent Colds				Poison Ivy			
Chicken Pox				Headaches				Rheumatic Fever			
Convulsions				Heart Trouble				Scarlet Fever			
Diabetes				Kidney Trouble				Sleep Walking			
Dizziness				Measles				Thyroid Disorder			
Ear Infections				Mononucleosis				Tuberculosis			
Epilepsy				Mumps							

Allergies	**Y**	**N**	**Events**	**Y**	**N**	**Date**
Hay Fever			Accidents			
Insect Stings			Operations			
Penicillin			Pregnancy			
Other:			Other:		Other:	

1. Please give all details concerning any disease or allergy to which "Yes" is answered previously, including names and addresses of physicians and hospitals.

   _____

   _____

   _____

2. Have you or any of your family suffered: any chronic or recurring illness, tuberculosis, mental illness, epilepsy, nervous breakdown, heart disease, asthma, diabetes or any other diseases?

   _____

   _____

   _____

If yes, give details, including names and addresses of physicians and hospitals and furnish specialist's letter (Only applies to applicant illness).

3. Have you undergone any operations or sustained any serious injuries? _____

   If yes, give details, including names and addresses of physicians and hospitals.

4. Are you taking any medications? Please state full pharmacological name and condition it is treating.

5. Have you ever consulted a psychiatrist or social worker? If so, give dates, reason and consultant's name, address and telephone number. A letter and a written detailed report from such a specialist giving complete diagnosis, prognosis and evaluation must be submitted.

6. Have you ever undergone psychoanalysis or received psychotherapy or other psychological treatment or advice? If so, give dates, reason and therapist's or advisor's name, address and phone number.

INSURANCE POLICY INFORMATION

Are you covered by health insurance? YES NO

Policy Holders Name:_____ Policy Holders Date of Birth:_____

Address:_____ Relationship to Participant_____

City, State/Territory, ZIP, Country:_____

Occupation:_____

Employers Name/Address:_____

Insurance Company Name:_____ Address:_____

Member #_____ Group #_____ Plan Type_____

I certify that I _____ (participant name) am insured under the above insurance and that the information is current and accurate. I have verified with my insurance company and/or agent that my health and accident insurance covers me in the place/country where I will be participating in EWH Summer/Winter Institute. I hereby assume responsibility for all medical expenses I incur and all medical expenses incurred on my behalf while I participate in and EWH Summer/Winter Institute Program.

I understand that I must make provisions before departure for the continuation of any medical treatments, the meeting of any special medical or nutritional needs, and the securing of any special services or facilities that I may need during the program. EWH makes no representation with respect to the availability or quality of any medical services or facilities available during participation in SI programs.

EWH strongly advises all participants of the desirability of keeping their medical insurance policies in good standing and checking with their provider regarding coverage outside of their home country. The insurance policy provided does NOT replace a medical insurance policy.

All above information must be filled out completely and will be treated as strictly confidential.

PHYSICAL EXAMINATION:

To be completed by a licensed medical professional.
This portion of the form may be substituted with a physical examination form from the physician's office.

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITY
Head	[ ]	[ ]	_____
General Build	[ ]	[ ]	_____
Neck	[ ]	[ ]	_____
Ears	[ ]	[ ]	_____
Eyes	[ ]	[ ]	_____
Teeth	[ ]	[ ]	_____
Mouth, Throat	[ ]	[ ]	_____
Chest, Lungs	[ ]	[ ]	_____
Heart	[ ]	[ ]	_____
Vascular /BP	[ ]	[ ]	_____
Abdomen, Viscera	[ ]	[ ]	_____
Hernia	[ ]	[ ]	_____
G.I. System	[ ]	[ ]	_____
G.U. System	[ ]	[ ]	_____
Upper Extremities	[ ]	[ ]	_____
Lower Extremities	[ ]	[ ]	_____
Spine	[ ]	[ ]	_____
Skin, Lymphatic	[ ]	[ ]	_____
Nervous System	[ ]	[ ]	_____
Mental State	[ ]	[ ]	_____

Height _____ Weight _____

Serological Tests (If known. Not required):
Hemoglobin _____ Blood Type _____ Rh _____

Vision:
Right - Without Correction _____ Left - Without Correction _____

Corrected to _____ Corrected to _____

Date of last vaccination against:

Tetanus _____ Hepatitis B _____ Hepatitis A _____

Typhoid _____ Measles _____ Yellow Fever (Africa only) _____

Diptheria_____ Whooping Cough_____ Salk (Polio)_____

Mumps _____ Rubella _____

Recommendations or comments:

_____

_____

Physician's Statement

I have read the "Notes to the Examining Physician" on pages 1 and 2 and thereafter have examined Mr./Ms. _____ and have recorded the results above which represent to the best of my knowledge, all the applicant's medical history and my findings on examination. **In my opinion the applicant is capable of participating in the program as outlined in the Notes**. I have known the applicant for ___ years. To the best of my knowledge the information on pages 7 and 8 are correct. I understand that EWH and their representatives will rely on my above report and findings.

Name _____

Address _____

Phone _____ Date _____

_____ _____
(Signature of Physician, Nurse Practitioner, or Physician Assistant) (License Number)

*If you become aware of a change in the applicant's medical condition, please notify Engineering World Health: summerinstitute@ewh.org.

Applicant's Statement, if over 21 years of age

I have read the "Notes to the Examining Physician" on page 1 and particularly items (V), (VI), (VII), (VIII) and (IX). I hereby certify that, to the best of my knowledge, the above medical form is complete in all its details and fully realize that any condition, mental or physical, that I am found to have originating prior to my arrival in my country of participation, and which is not described in full in this form or in any accompanying letter, will be due cause for my return to my country of origin or treatment solely at my expense, and that EWH and their representatives have neither responsibility or liability arising out of such condition. I also realize that medical coverage does not include dental treatment of any form whatsoever, or eyeglasses. All medications that I take regularly are at my own expense, and have been detailed in this form or in letters. I also give my full permission for all treatment of any nature deemed necessary by doctors in the host country to be extended to me within the framework of the Medical Services of EWH representatives. I also acknowledge the fact that usage or involvement with alcoholic beverages, drugs or narcotics or any other anti-social behavior may be cause for immediate dismissal from the EWH Summer/Winter Institute, and I will be returned home at my own expense.

Name of Applicant _____

Applicant Signature _____ Date_____

Parent or Guardian Statement

(IF applicant is under 21 years of age)

I hereby certify that the attached Physician's Health Statement was completed by the physician only after examination of the applicant, _____. This is a full and complete statement of the applicant's health submitted to you as part of the application for admission to EWH Summer/Winter Institute.

I understand that the medical care provided for participants in the EWH Summer/Winter Institute does not include pre-existing conditions (i.e. allergies, asthma, ulcers, previous operations, etc.), eyeglasses, pregnancy or dental treatment of any kind. The attached physician's statement of health states in detail all medications which applicant is required to take regularly, and such medication will be supplied by the applicant at his/her expense.

I understand that if, after arrival in the country of participation, applicant becomes ill or unable to participate in the EWH Summer/Winter Institute, and such illness or inability is the result of any pre-existing or undisclosed condition of which EWH Summer/Winter Institute had no knowledge, applicant may not be permitted to continue in the EWH Summer/Winter Institute, and any medical treatment will be at his/her expense. I also understand that if it is decided that applicant should not continue in the EWH Summer/Winter Institute, applicant will be returned home at his/her expense. If, while applicant is in a host country, any medical treatment is needed, I herewith give full permission for all such treatment by physicians in the host country to which the applicant may be taken or referred by you.

I acknowledge that the usage of, or involvement with any drugs or narcotics (except those prescribed by a physician for medical treatment), will result in immediate dismissal of the applicant from the EWH Summer/Winter Institute, and applicant will be responsible for all expenses resulting from such involvement and dismissal.

Applicant Name (please print) _____

Parent or Guardian Signature _____Date_____

Relationship to Applicant_____

Address _____