Health Assessment Form

To the Primary Provider (Physician, Physician Assistant or Nurse Practitioner):
Your patient has applied to participate in a year-long volunteer experience serving the poor in either Syracuse, NY or Alajuela, Costa Rica. ***The FrancisCorps experience is rewarding but also physically, emotionally and spiritually challenging.*** During that time the applicant will be living in close quarters with 5 or 6 other young adults from North America in their volunteer house. The volunteers will also spend the year serving the poor. While universal hygiene precautions are encouraged, the volunteers will be in close contact with children and adults who may not have optimal hygiene or health and who often have limited access to medical services. ***Volunteers need to be in robust physical and mental health***.

Applicant

Name:

Date of Birth:

Length of time applicant has been your patient:

Date of last complete physical exam:

General Information

Past illnesses (last 10 years):

Past hospitalization or surgeries(last 7 years):

Alcohol & Drug History:

Family History

Significant medical/psychiatric:

Current Personal

Medicines (including non-prescriptive):

Significant present medical/psychiatric:

Allergies, dietary restrictions:			
Tobacco use: /day		Alcohol use /day	
Disabilities:			
General Physical			
Ht:	Wt:	BP:	P:
Do you have any medical concerns about the applicant's ability to lift over 50lbs, walk 3 miles continuously, climb stairs, travel by car over 5 hours and complete tasks of daily living such as cleaning, cooking, etc.? ☐ No ☐ Yes (Please describe)			
Laboratory	UDS ***required***:	PPD ***required***:	CBC:
UA:	CMP:	TSH T3 T4:	TC:

Required Vaccinations	
Please verify that the applicant has the vaccinations / booster / immunity that are required.	
DTP/DTaP *(required)*	*Date Given:*
Tdap *(required)*	*Date Given:*
MMR *(required)*	*Date Given:*
Hepatitis A *(required)*	*Date Given:*
Hepatitis B *(required)*	*Date Given:*
Varicella *(required)*	*Date Given:*

Primary Provider Information	
Primary Provider's Name:	
Address:	
Provider's Signature:	Date: