Medical Clearance Form

Your patient (Name, DOB)	wishes to take part in
an international agricultural volunteer program involving trav	vel to
The voluntary assignment may involve light physical activity	y, and the volunteer may spend significant
amounts of time on farms and in the proximity of livestock. A	ccess to modern medical facilities, medicine
and equipment may be limited or unavailable in the ru	ral areas in which the volunteer will be
working. The volunteer will travel within the country by o	car; road conditions may be poor and the
volunteer faces a risk of road traffic accidents. Travel to the	
number of risks, such as infectious diseases including mal	·
temperature extremes, exposure to different altitudes, and	•
ailments. The volunteer will be lodged in the homes of host f	
If you know of any reason why your patient's involvement	•
	. III tilis program would be unwise, please
indicate so on this form.	
CRS and your patient named above request you to provide you	ur professional judgment as to your patient's
	, , ,
suitability to participate in this program on the form below.	This form will be considered valid for one
year from the date of signature unless otherwise indicated.	
The patient's general physical exam reveals no reason	on why he or she may not participate.
I believe my patient can participate, but urge cautio	n herause.
I believe my patient can participate, but dige caution because.	
	
My patient should not engage in the following activi	ties:
, patient should not engage in the following doctor	
I recommend that my patient NOT participate.	
recommend that my patient <u>i.v. p</u> articipates	
Known Allergies:	
Physician Name (Print):	
Physician signature	Date:
Trysician signature	
Address	-
City, State	
ZipTelephone	E-Mail
,	