Farmer-to-Farmer Medical Clearance Form

Your **patient** (Name, DOB) _____wishes to take part in an international agricultural volunteer program involving travel to _____.

The voluntary assignment may involve light physical activity, extended periods on farms, and proximity to livestock. The volunteer might encounter limitations in access to modern medical facilities, medicine, and equipment, especially in rural areas. Additionally, travel involves road transportation, potentially on poor road conditions, posing a risk of road traffic accidents. Various risks are associated with travel, including exposure to infectious diseases (malaria, tuberculosis, among others), possible temperature extremes, changes in altitude, and the risk of food and waterborne diseases. The volunteer will be accommodated in host families' homes or apartments.

Your professional judgment is crucial in assessing the suitability of your patient for this program. If there are any reasons why your patient's involvement would be unwise, kindly indicate them on the form. CRS and your patient appreciate your input, and the information provided will be considered valid for one year from the date of signature unless otherwise indicated.

Physician Recommendation

☐_____ The patient's general physical exam reveals no reason why he or she may not participate.

☐_____ I believe my patient can participate, but urge caution because:

_____

☐_____ My patient should not engage in the following activities:

_____

☐_____ I recommend that my patient **NOT** participate.

☐_____ Known Allergies: _____

I certify that I have completed a comprehensive physical exam and advised the patient to seek further guidance regarding pre-deployment health review, including vaccinations, preventive practices, destination-specific health risks, prohibited medications, and malaria prophylaxis, from an authorized travel clinic. I certify that there are no existing health conditions for the patient that pose a risk of exacerbation at the area of deployment.

Physician Signature: _____

Physician Name (print): _____ **Date:** _____

Practice Name:_____

Address:_____

Telephone Number: _____E-Mail Address: _____

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