

MEDICAL REPORT for ECOLOGY ACTION INTERN APPLICANTS

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This report must be completed by a licensed doctor who has examined the applicant to the internship program and knows his/her medical history.

Upon completion of the form, please either FAX it to Ecology Action in the U.S. at +1-707-459-5409 or scan it and email it as either a PDF or a JPEG to contact@growbiointensive.org.

In either case, please include "Internship Application Medical Form for {patient's name}" as the subject line in the fax or email, so that we know who the form belongs to.

Name of the Patient: _____ Height: _____ Weight: _____ Sex: **M/ F**

Date of the examination: ____/____/____ Examination location (city): _____

Name of Doctor: _____ License number: _____

Doctor's Contact Information: _____

1) How long have you known the patient? _____

2) Does the patient or any close relative have a contagious disease? **Yes /No**

If you answered yes, please describe:

3) Does the patient have any history of serious injury, illness or disease? **Yes /No**

If the answer is yes, please describe the condition, duration of the treatment, age of the patient at the time of treatment, and final result of the treatment:

4) Please test the patient for tuberculosis. Did this patient test **Negative** or **Positive** for TB?

5) Is the patient currently taking any prescription medicine or in need of ongoing medical treatment? **Yes / No**

If the answer is yes, please describe the medicine and reason for treatment:

6) Is the patient allergic to penicillin, other antibiotics or other medications? **Yes / No**

If yes please specify: _____

7) What year did the patient last receive a vaccination for Tetanus? _____

If longer than 5 years ago, please administer now and provide the date of the injection: ____/____/____

8) Does the patient smoke? **Yes / No**

If the answer is yes, how many cigarettes per day? _____

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9) Does the patient drink alcoholic beverages?

Never **Occasionally** **Frequently** (more than 5 times per week)

10) Check the box if the patient has problems or previous history with any of these conditions:

- | | | |
|---|---|---|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> nervous disorder |
| <input type="checkbox"/> dental problems | <input type="checkbox"/> back problems | <input type="checkbox"/> anemia |
| <input type="checkbox"/> gum disease | <input type="checkbox"/> joint problems | <input type="checkbox"/> fatigue/lack of energy |
| <input type="checkbox"/> allergies | <input type="checkbox"/> diabetes | <input type="checkbox"/> appetite loss |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cancer | <input type="checkbox"/> drug addiction |
| <input type="checkbox"/> skin condition | <input type="checkbox"/> HIV+ | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> organs | <input type="checkbox"/> sexually transmitted disease | <input type="checkbox"/> obesity |
| <input type="checkbox"/> underweight | <input type="checkbox"/> ulcer | <input type="checkbox"/> cough |
| <input type="checkbox"/> lack of mobility | <input type="checkbox"/> hearing loss | <input type="checkbox"/> infection |
| <input type="checkbox"/> broken/improperly healed bones | <input type="checkbox"/> poor eyesight | <input type="checkbox"/> depression |
| <input type="checkbox"/> bleeding | | <input type="checkbox"/> Other. |

If you checked any of the boxes, please describe:

11) This patient has applied to join a U.S. farm-training program. This program requires daily, physically rigorous activity. Is there any medical reason that might prevent the patient from performing well in such a program? **Yes / No**

If the answer is yes, please explain:

12) Please indicate the general health of the patient: **Excellent** **Good** **Fair** **Poor**

Doctor's name: _____

Signature: _____ Date: ___ / ___ / ___

Official Stamp: