**MEDICAL MISSION TEAMS PHYSICIAN’S RELEASE FORM**

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Volunteer Name Birthdate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Height Weight

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code Date of Last Physical Exam

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies

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Travel Vaccinations Received (With Dates)

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Current Prescribed Medications or Therapies

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Chronic Medical Conditions

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Health Maintenance Equipment Used by Volunteer (Nebulizer, CPAP Machine, etc.)

Dear Physician:

Your patient will be volunteering overseas with Medical Mission Teams. This service may be physically demanding in ways which will require your patient to:

* endure hot or uncomfortable weather temperatures or work conditions;
* walk 2 miles at a comfortable pace;
* lift 50lbs. on occasion and handle personal luggage and carry-ons;
* be free of all currently unmanaged health conditions;
* have all electrical health maintenance equipment available to use on battery power;
* have an adequate supply of all prescribed medications for the duration of the trip;
* have finished all required immunizations for this geographical region of travel recommended by the U.S. Centers for Disease Control.

**\_\_\_\_\_ I certify that the above information is true concerning the above patient in my care.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Physician Name (Printed)

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Physician Address Physician Phone Number

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