USM
Dominican Republic
Medical Information and Form

Part I: CONDITIONS SPECIFIC TO THE DOMINICAN REPUBLIC PROGRAM

Traveling to a different environment may pose emotional and physical challenges. It is important that you provide us with as much information as possible so that we can prepare you for your overseas program and assist you with any accommodations. The information provided in this form will not be used to exclude you from the program unless it has been determined your participation poses a significant risk of substantial harm to yourself or others. The information is for use in the event of an emergency or other health matter. The information provided will remain confidential.

This form must be completed by you or by a parent/guardian if you are not legal age. You must return this form to the Office of International Programs by the due date or you will not be able to participate in the program.

The Dominican Republic Health Outreach Program is made up of volunteers, faculty and students. Your support system needs to understand that it is not a vacation. Please share the conditions with them. Hundreds of people have done it safely, but we have had every type of health outcome including a fatal accident, so we know that the possibilities are not hypothetical. Other volunteers may be your best source of medical assistance in the DR, and the faculty reserves the right not to include you if they feel that you will not be reasonably safe.

Please assure USM that you understand all the following conditions of participation. You must be in excellent mental and physical health, able to work long days and hike in the rain at times. Your transport to mountain villages daily is in rented or local vehicles over hilly dirt roads. You are required to get extra vaccines at your own expense. You may be exposed to many tropical and contagious diseases and are responsible for your own follow-up care and treatment. Sharps accidents (needle sticks) can occur, and you must guard against them. There is no safe hospital available to you in country, no safe blood supply, no EMTs, and no 911 or trauma care. Electricity and phones in our area are not dependable. Cell and satellite phones are just beginning to work.

Simple housing in a rural religious retreat includes triple bunk rooms with running water (NOT potable), toilet and shower room with door, and mosquito nets on bunk beds. Nets are not provided with permethrin and you may need to repair holes. Drinking water is purchased in bottles but cannot be tested. You must bring and carry a personal refillable water bottle at all times. Food is cooked daily on site by local staff. Vegetarians can eat a variety. "Traveler's diarrhea" and upper respiratory infections are common. Smoking and alcohol use should be extremely limited, especially in our home and partnership communities. Marijuana and other substances are illegal and use is cause for dismissal without course completion.

This list is not exhaustive; there may be other unforeseen risks. You must seriously consider these conditions before committing to the program.

Permission to share information

I, _____, grant the faculty members leading this program and health providers permission to view all parts of this Medical Form and discuss any concerns with me.

Signature _____ Date _____

Name Printed _____

Return the completed medical form to:

Larisa Kruze, Office of International Programs, 101 Payson Smith Hall, PO Box 9300, Portland, ME 04104

Return all three sections of this health report in a sealed envelope with your name clearly on the front to ensure confidentiality until it gets to the authorized personnel.

Due Date: April 30, 2010

USM Summer/Winter International Programs Medical Form

Part II To be completed by the student.

1. Name _____ Program _____

Birth Date _____/_____/_____ Sex ____ Height ____ Weight _____ Blood Type (if known) _____

2. Home Address: _____

You reside with: ___ parent ___ spouse _____ Other _____

Emergency Contact #1(First contact)

Name _____ Relationship to You _____

Home Address _____City _____

State____ Zip_____ Best Phone(s)_____ E-mail_____

Emergency Contact #2 (Second contact)

Name _____ Relationship to You _____

Home Address _____City _____

State____ Zip_____ Best Phone(s)_____ E-mail_____

3. Do you have any known allergies to medications or vaccines? ❑ **Yes** ❑ **No** If yes, please explain.

_____

_____

4. Will you receive all vaccines recommended by USM and the CDC one month prior to your overseas program?
❑ **Yes** ❑ **No** If no, please explain.

_____

_____

5. Do you have any food allergies or dietary restrictions? ❑ **Yes** ❑ **No** If yes, please explain.

_____

_____

6. Do you carry an epi-pen and/or medicines? ❑ **Yes** ❑ **No** If yes, please explain.

_____

_____

7. **Check** all of the following conditions you have had or currently experience.

____ Anemia
____Arthritis or Mobility Issues
____ Asthma
____ Blood Clotting Disorder
____ Cancer
____ Cardiac condition
____ Diabetes
____ Epilepsy/Seizures
____ Fainting/Blackouts
____ GI disorder
____ Hearing Impairment
____ Immune System Problem/ Immunosuppressant treatment
____ Kidney Disease
____ Latex Allergy
____ Lung condition
____ Mental Health Condition: (Anxiety, Panic attacks, depression, bipolar disorder, ADHD, Substance dependency, other_____)
____ Skin (eczema, psoriasis)
____Other _____

❑ I have reviewed the list above and none of the conditions does or did apply to me.

Give diagnosis and explain any recent or serious health episodes (use additional paper if necessary).

_____

8. Last intradermal tuberculin test (PPD) or X-ray (must be within one year of departure).

Date: _____ Results _____Where it was completed _____

Permission for emergency treatment
In the event I am unable to make rational decisions regarding my medical care and my emergency contacts cannot be reached, or if the delay may cause serious danger to me, I authorize medical and/or surgical treatment as may be deemed necessary or advisable for me (or my child). I also authorize the release of medical information to insurance companies for the purpose of payment, and to health care providers who may treat me (or my child).

Signature _____ Date _____

Part III To be completed by a medical provider.

1. Is the information provided by the student in Part I complete and correct to the best of your knowledge?
   ❑ **Yes** ❑ **No** If no, please explain.

_____
_____

2. Is the student currently on medication or receiving medical treatment? ❑ **Yes** ❑ **No** If yes, please explain.

_____
_____

3. Will the student continue medication while abroad? ❑ **Yes** ❑ **No**

4. Has the student had any recent medical conditions or surgeries that could require attention while traveling abroad? ❑ **Yes** ❑ **No**

Please note any other information, including details of current treatment, which could be helpful to a physician treating this student while overseas (use additional paper if necessary). Take into account the risks described in the introduction.

_____
_____
_____
_____
_____

5. Does this student have any ongoing physical or emotional condition, disability, or impairment that poses a significant risk of substantial harm to themselves or others? Please take into account the risks described in the introduction. ❑ **Yes** ❑ **No** If yes, please elaborate.

_____
_____
_____

6. Date of last examination (*within the last 12 months).* _____

Signature
_____Date_____

❑ Physician/ Nurse Practitioner/or Physician Assistant's name (print)
_____

Street Address _____ City _____ State ___ Zip _____
Phone (_____) _____ Ext. _____