



# PHYSICIAN CERTIFICATION

To be completed and signed by a licensed physician. PLEASE PRINT CLEARLY.  
Please list immunizations **on this form** rather than attaching additional sheets of paper.

This form is intended to certify that your patient, \_\_\_\_\_, is medically able to participate in the American Jewish World Service ("AJWS") program described below ("Program"). As part of the Program, your patient may travel to and visit an extremely rural area with only rudimentary sanitary facilities. The conditions your patient will face will be physically and mentally demanding. Please complete this certification in order to help us determine your patient's ability to participate in the Program.

**BRIEF DESCRIPTION OF PROGRAM:**

Volunteer Summer is a service-learning program in which groups live and work in rural communities, in various developing countries. Groups spend an average of six (6) hours a day working on a manual labor project that often includes a significant amount of bending, kneeling and heavy lifting. Though volunteers take regular water and rest breaks during the work day, they work hard for many hours each day, outside in extreme heat, under bright sunlight, often in dry and dusty environments. The communities in which the groups live are typically within 30 minutes of a local clinic and within 3-5 hours of a major hospital. Accommodations are rustic and food is prepared by a local cook. Trip duration is 50 days.

To be completed by physician/practitioner:

**HEALTH HISTORY:**

Please check the boxes next to each of the conditions your patient has had in his/her health history:

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Rheumatic Fever
- Substance abuse
- Alcohol abuse
- Mental illness
- Social or behavioral disorders

**IMMUNIZATION HISTORY/DATES (DO NOT attach a separate page)**

Please check the box next to each of the immunizations your patient has had and indicate the date (mm/yy) of immunization:

- DPT \_\_\_\_\_
- Polio OPV (Sabin) \_\_\_\_\_
- MMR \_\_\_\_\_
- Smallpox \_\_\_\_\_
- Tetanus Booster \_\_\_\_\_
- Hepatitis A \_\_\_\_\_
- Hepatitis B \_\_\_\_\_
- TB Mantoux Test (date of last test and result) \_\_\_\_\_
- Meningitis \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Pertussis \_\_\_\_\_

- Diphtheria \_\_\_\_\_
- Yellow Fever \_\_\_\_\_
- Typhoid \_\_\_\_\_

**PATIENT'S EMERGENCY MEDICAL NEEDS:**

Does your patient wear a medical alert bracelet, or may patient otherwise require emergency medical care because of an underlying medical condition? If so, please explain nature of patient's medical condition, any health restrictions associated with that condition, and the type of emergency care that your patient may require:

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Does your patient have diabetes? If so, are his/her activities restricted in any way? If so, please explain:

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Does your patient's blood type or other condition make patient less amenable to transfusion? Please explain.

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Does your patient have any underlying or pre-existing medical conditions that may call for emergency medical treatment and/or that AJWS or emergency care practitioners should be aware of (including in case your patient is unable to communicate for him/herself)? \_\_\_\_\_

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Is your patient currently under the care of a psychiatrist or psychologist (if yes, please provide name and address)?

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Is your patient currently suffering from mental health, social, or behavioral illnesses or disorders (or does your patient have a history of any such illnesses or disorders) that would impact his/her ability to participate successfully in the Program or in a group or social environment (if so, please explain):

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**PATIENT'S KNOWN ALLERGIES (please include allergies to medications):**

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**PATIENT'S MEDICATIONS/RESTRICTIONS:**

Your patient is on the following medications (please describe dosage, time of day taken, reason, and any other instructions): \_\_\_\_\_

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Your patient has discontinued the following medications in the last six months (please describe dosage, reason for discontinuation, and any other pertinent information): \_\_\_\_\_

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Please identify and explain any recommended restrictions to your patient's activities: \_\_\_\_\_

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**OTHER PERTINENT INFORMATION/COMMENTS:**

Please provide any additional information you believe would be of interest.

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**CERTIFICATION:**

I have examined this individual and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in the Program described above, except as otherwise noted.

\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number