

HEALTH FORM – Page to be Completed by Physician
Intercambio Cultural Maya
December 27, 2010 – January 8, 2011

Participant/Patient Name (please print) _____

This trip will include travel to and from Mexico, visiting a remote village, sleeping in hammocks, eating different foods, drinking only purified water, transportation on crowded public buses, and *strenuous* physical work done in the Mexican winter heat.

The **Intercambio** leadership team should be aware of the following **medical or emotional conditions or physical limitations** of this patient:

This patient has the following **allergies** (include any medications to which this patient is allergic).

List **ALL MEDICATIONS** this patient is taking (include **dose and frequency** of administration).

I have examined this patient and found her/him in general good health and able to withstand the travel and lifestyle this trip will involve (as noted above).

Physician Signature _____ **Date** _____

Print/Type/Stamp Physician Name _____

Clinic Name (Please print) _____

Clinic Mailing Address _____

City _____ STATE ____ Zip Code _____

Phone Number __ (____) _____

Note to Physician: The immunizations and medications required by Intercambio Cultural Maya for this patient to participate are listed on page 2 of this Health Form. Please consult page 2 with your patient.

Page 2 of 2 must be completed, signed, and dated by Participant (or parent if under 18)

HEALTH FORM – Page to be Completed by Participant

Intercambio Cultural Maya

December 27, 2010– January 8, 2011

Participant Name (please print) _____

I understand that the following immunizations and medications are recommended by the Centers for Disease Control for the area and conditions of this project and are required by Intercambio Cultural Maya. **I also understand that both pages of this original form MUST be returned to Intercambio by November 21, 2010**

By signing below, I certify that these immunizations and medications have either been completed or have been started and will be completed prior to December 27, 2010:

TETANUS AND DIPHTHERIA, MALARIA TABLETS, TYPHOID, HEPATITIS A VACCINE, and I WILL DISCUSS/HAVE DISCUSSED TRAVELER’S DIARRHEA with my physician.

Signature _____ (Printed Name) _____ Date _____

*Parent Signature _____ (Printed Name) _____ Date _____

* (If Participant is under 18 years of age)

NOTE: Both pages 1 and 2 are due November 21, 2010.

Page 1 must be completed, signed and dated by your physician, and
Page 2 must be completed, signed and dated by you, the participant (or parent if under 18).

After the physician has signed page 1 of this form, please sign the second page to certify that you have either completed or have started and will complete the immunizations and medications listed above. Promptly return this 2-page form to Intercambio (*Do not rely on the physician’s office to mail this form – mail it yourself.*).

DO NOT WAIT TO SEND THIS FORM UNTIL YOU HAVE COMPLETED TAKING THE MEDICATIONS.

PLEASE NOTE: In order to complete the Health Form by the deadline, start the process with your physician immediately after receiving a letter of acceptance.