Patient's Name: _____
Sex Assigned at Birth: _____

CONFIDENTIAL PHYSICAL HEALTH FORM

(To be completed by Volunteer's Primary Care Physician)
Final Acceptance & Project assignments are dependent on completion, submission, and assessment of this form.

Attention Applicants & Parent/Legal Guardians:

- **Please read the "General Health Criteria for AMIGOS Participation" before bringing this form to your health care provider.**
- **If during the past two years you received outpatient mental health, inpatient psychiatric, or chemical dependency services, a copy of the separate confidential Mental Health Clinician form must also be completed by all treating Mental Health clinicians. Their signature and full contact information must be included at the bottom of that form (e.g. a Psychiatrist, Nurse Practitioner, Psychotherapist of any discipline). It is important that your health care provider be aware of the rural, sometimes under-developed conditions in which our volunteers may live and, therefore, indicate any condition(s) which may affect your participation.**
- **Any additional forms your physician/clinician(s) wish to include may be attached; however, this form must be completed in full.**

Attention Physician/Clinician:

Your patient is requesting an examination to participate in Amigos de las Américas for a period of up to 6 weeks (for volunteer applicants), 3-4 months (for Project Staff Team applicants), or up to 9 months (Gap Program applicants). Please remind your patient that he/she must receive all vaccinations and necessary project-specific prophylaxis (e.g. typhoid vaccination) required by AMIGOS. AMIGOS Programs can be physically and emotionally challenging. Volunteers must be able to function relatively independently under stressful conditions. They will be supervised by adults who are not health professionals, but mentors and guides. Conditions the volunteer may face include, but are not limited to the following:

(a) rudimentary living conditions;
(b) lack of clean, disinfected water;
(c) extreme climatic conditions which may include heat, cold, high altitude and long periods of rain;
(d) a dramatically different diet; and
(e) different and stressful cultural settings which may be emotionally challenging.

Additionally, medical and pharmaceutical services might not be immediately available and might not be available at a level equivalent to those in the United States or the volunteer's country of origin. Disclosure of a medical condition does not automatically disqualify an applicant from admission to the program but may result in further screening to determine the appropriateness for AMIGOS service.

This confidential medical report will be reviewed by the appropriate AMIGOS staff members and physical and mental health consultants and copies are available for review by staff. Please return this form to your patient for submission to our National Office. For this form to be considered complete, each page must be initialed, and the final page must be signed.

If you have any questions about this form and or AMIGOS, call 713-782-5290 (or toll free at 1-800-231-7796) and ask to be connected with the "Director of Health and Safety" or send an email to healthandsafety@amigosinternational.org. For additional information about AMIGOS please visit our website: www.amigosinternational.org

(1) Do you consider your patient psychologically and physically stable enough to responsibly handle the stresses of the AMIGOS project assignment? *(Please refer to the above "Attention Physician/Clinician" for a description of the AMIGOS Program.)*

- ☐ Yes
- ☐ No

Comments:

(2) During the AMIGOS Program your patient may experience a dramatic change in diet. Has your patient been able to independently maintain adequate nutrition in the past and do you think that your patient will be able to do so during the AMIGOS Program, considering a high level of independence & a new & unfamiliar diet?

- ☐ Yes
- ☐ No

Comments:

(3) Does your patient have any of the following dietary restrictions or require a special diet?

- ☐ Lactose Free
- ☐ Dairy Free
- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Intolerance or Sensitivity
- ☐ Kosher
- ☐ Keto
- ☐ Diabetes
- ☐ Low carb
- ☐ Food allergies
- ☐ None of the above

Comments:

In your judgment as a clinician, please document any mental or physical conditions that are of potential concern to your patient's successful participation in AMIGOS.

MEDICAL HISTORY

Medications. Over the Counters, Supplements, and Vitamins

Please list all prescription, over the counter, and natural medications your patient is currently taking. If additional space is needed, please write on the back of this form.

Medication Name	**Dosage** (e.g. 5mg)	**Frequency** (e.g. 2x/day)	**When was medication prescribed** (e.g. 1/1/2013)	**Who is the prescribing provider?**	**Side Effects (include potential)**	**Reason for Taking**	**Will take medication during AMIGOS service program?**
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No

*If more space for medications is needed, please continue on back

1) Do you consider your patient to be stable on their current medications?

   ☐ Yes
   ☐ No

   Comments:

2) Do any medications require constant refrigeration or frequent adjustments and monitoring?

   ☐ Yes
   ☐ No

   Comments:

3) Do you consider your patient capable of caring for and administering his/her own medication as prescribed?

   ☐ Yes
   ☐ No

   Comments:

Allergies

1) Include medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.) or select No known allergies.

Allergy	Reaction	Medication Required (e.g. EpiPen), if any	Will take medication during AMIGOS Latin American service program?
			Yes No
			Yes No
			Yes No

2) Describe the severity of your patient's allergies.

_____

_____

General Health History

Please list any medications related to the below conditions on the previous page.

1) Does your patient have any (or have a history) of the following? Check "Yes" or "No" for each statement. Explain "Yes" answers below. :

	YES	NO
Hospitalization		
Surgery		
Recurrent/chronic illnesses		
Recent infectious disease		
Recent injury		
Asthma/wheezing/shortness of breath		
Migraines or headaches		
Seizure disorder		
Disordered Eating (Avoid Restrictive Food Intake, Picky Eating, Anorexia Nervosa, Bulimia, Binge Eating)		
Skin disorders (Eczema, Atopic dermatitis, psoriasis, hives, contact allergies)		
Dengue		
Diabetes		
Wear glasses, contacts, or protective eyewear		
Had fainting or dizziness		
Passed out/had chest pain during exercise		
Any orthopedic/neurologic condition that impairs your patient's mobility		
Any congenital medical conditions (e.g. congenital heart disease)		
Hypertension		
Altitude sickness		
Recent physical injury or disability (causing any limitations in walking long distances, lifting objects, doing construction tasks, etc.)		

Any other health condition that may need to be taken into consideration? If yes, please describe below
If you answered "yes" to any of the above, please explain the severity of each of your patient's condition(s).

2) Does your patient see a specialist? If so, please write name, specialty, and reason for care.

Mental, Emotional and Social Health

1) Does your patient have any (or have a history) of the following? Check "Yes" or "No" for each statement. Explain "Yes" answers below

	YES	NO
Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)		
Ever been treated for emotional or behavioral difficulties including anxiety, panic attacks, depression, mania, or mood swings		
Ever been treated for an eating disorder (Avoid Restrictive Food Intake, Picky Eating, Anorexia Nervosa, Bulimia, Binge Eating)		
During the past 12 months, seen a professional to address mental/emotional health concerns?		
Ever taken medication for a mental health condition?		
Had a significant life event that continues to affect the patient's life? (History of abuse, death of a loved one, family change, survived a disaster, others)		

If you answered "yes" to any of the above, please explain the current status of each of your patient's condition(s).

I have inquired of my patient and to the best of my knowledge, my patient does not currently, and has not in the past two years, had any psychiatric/psychological treatment by any mental health professional.

(initials)_____

OR

My patient is currently seeing a mental health professional or has seen a mental health professional for treatment of a psychiatric/psychological condition, in the past two years, and I will defer to that clinician re my patient's current mental health status & emotional readiness for the AMIGOS program.

(initials)_____

Primary Care Physician's Signature _____ Date _____

Physician's Name (please print) _____

Street Address _____City _____

State _____ Zip Code _____ Phone (_____)_____

Applicant signature

_____Date_____

Parent signature (if under 18) _____Date_____