Physician's Medical Information Form

Participant Name: ____

Warm Heart Foundation, Inc. Volunteer/Internship/Coop Program

Please have your physician answer the following questions on these two pages, sign and date below.

This individual has been accepted into the Warm Heart Foundation, Inc. (Thailand) volunteer/internship/coop program. In the interest of his/her safe and successful participation, we would appreciate your cooperation in answering the following questions and adding any information that you feel is relevant to his/her ability to participate in a program in northern Thailand. This information will remain confidential and wilt be provided only to the Volunteer Manager of Warm Heart Foundation, Inc. and those with a need to know for the purpose of providing any necessary accommodations or in the event that medical attention is necessary.

1. Does the student have any dietary restrictions or known food allergies, allergies to medication or other allergies that Warm Heart Foundation should be aware of in the event of an emergency?

   ☐ Yes ☐ No

   If yes, please describe below or attach additional sheets if necessary.

2. Is the individual taking any medications, or will the individual be taking any medications while abroad, that the Warm Heart Foundation should be aware of in the event of an emergency?

   ☐ Yes ☐ No

   If yes, please describe below or attach additional sheets if necessary.

3. Is the individual aware that she/he may not be able to obtain certain necessary medications in Thailand or may need to purchase the generic versions?

   ☐ Yes ☐ No

4. Are all routine immunizations up to date?

   ☐ Yes ☐ No

5. Travel and work abroad necessarily involve stress due to exposure to different cultural and physical environments, as well as the potential for possible experience with a medical and health care situation different from that found at home. Is this individual able to participate safely and successfully in the Warm Heart Foundation volunteer/internship/coop program?

   ☐ Yes ☐ No

   If no, please describe below or attach additional sheets if necessary.

6. Does the student require accommodations to a disability to enable her/him to participate safely in the Warm Heart Foundation program?

   ☐ Yes ☐ No

   If yes, please describe below or attach additional sheets if necessary.

Physician's Name: ______________________________
Date: ______________________________
Signature: ______________________________
Address: ______________________________
____
Phone: ______________________________

Please mail the completed form to:

Warm Heart
P.O. Box 8
Phrao
Chiang Mai 50190
Thailand