Engineering World Health Institutes
Medical Examination Form

Notes to the Examining Physician

(I) The new and strenuous environment encountered during the EWH Institutes will tax each participant's physical and mental capabilities - they will be adjusting to a new country, language, and culture while applying newly-learned skills in a potentially high-pressure hospital environment. As a safeguard to the health of the participant, this report should be as complete and precise as possible. A full travel medicine appointment is highly recommended to cater to specifics of the participant's destination, which may include prophylaxis, vaccines, and general advice on food, water, and activities. This form is a guide and may not cover all the possible medical considerations.

(II) Participants will be working in temperatures ranging from 40 to 110 degrees Fahrenheit (4 to 43 Celsius).

(III) Medical facilities available for participants will only cover acute illness and accidents. There are no facilities available within the program period for the treatment of chronic ailments. The management of chronic ailments should be prepared for by the participant.

(IV) Any participant who has been under the care of a specialist must submit a written detailed report from said specialist giving complete diagnosis, prognosis, and evaluation of fitness for participation. The World Health Organization recommends caution when traveling to the developing world if a person suffers from cardiovascular disorders, chronic hepatitis, chronic inflammatory bowel disorders, chronic renal disease requiring dialysis, chronic respiratory diseases, diabetes mellitus, epilepsy, immunosuppression due to medication or HIV, previous thromboembolic disease, severe anemia, severe mental disorders, or any chronic condition requiring frequent medical intervention. If the participant suffers from any of these conditions, please discuss the condition(s) and traveling to the intended destination with the participant.

If a participant is required to continue therapy or treatment, or to continue receiving medicines and drugs during the program, they should provide a medical letter giving full details. Medications may not be available in our program countries. There are also challenges with fake/adulterated medication or medication under a different trade name than in the country of origin; therefore, the participant must have enough needed medications to cover the duration of the Institute, and the full pharmacological name of all medicines and drugs must be provided on this form. Failure to submit such a letter with a detailed list of medications and pharmacological names shall result in expulsion of the participant from the Institute without any refund.

If any changes take place in the participant's condition **within the 10 days before departure**, the participant must submit, before departure, a full, explanatory medical letter, detailing the medical event, treatment, prognosis, and fitness for travel. Failure to submit such a letter shall result in expulsion of the participant from the Institute without any refund.

(V) EWH intends to rely on this completed form and supplementary letters in making determinations of continuation of the participant in the program. Omissions or mis-statements are at the risk of the participant and the physician, surgeon, psychiatrist, psychologist, or social worker.

(VI) The information on this report form and all supplementary letters and reports on the physical, mental, or psychological condition of the participant shall be held by EWH as strictly confidential. Additional privacy needs beyond confidentiality should be communicated if needed.

(VII) The decision to take or not take malaria prophylaxis is an individual decision that should be discussed with a qualified physician. EWH is not responsible in any way for a participant's decision regarding malaria prophylaxis or that decision's consequences.

(VIII) The air quality of the participant's destination should be considered. Large cities of some developing nations (i.e. Kathmandu in Nepal) have high levels of pollution. This may cause problems for participants with asthma, allergies, or other respiratory concerns.

(IX) Medical records submitted by participants may be accessed by full-time EWH employees and contracted EWH staff. This information will be saved in a secure online file management system.

(X) **SHOULD ANY PARTICIPANT UPON ARRIVAL, OR DURING THE INSTITUTE, BE FOUND TO HAVE ANY CONDITION, MENTAL OR PHYSICAL, THAT IS NOT FULLY DISCLOSED IN THIS MEDICAL FORM, ACCOMPANYING LETTER OR IN AN ATTACHED PSYCHOLOGICAL PROFILE THEN, (1) HE OR SHE MAY, AT THE SOLE AND ABSOLUTE DISCRETION OF EWH OR ITS REPRESENTATIVES, BE RETURNED TO THE PLACE OF ORIGIN AT THE PARTICIPANT'S OWN EXPENSE, OR MAY BE TREATED, AT THE PARTICIPANT'S OWN EXPENSE, AND THERE SHALL BE NO REFUND OF MONIES PAID FOR THE INSTITUTE, AND (2) EWH AND ITS REPRESENTATIVES ARE THEREBY RELEASED OF ALL RESPONSIBILITY OR LIABILITY OF ANY KIND WHATEVER ARISING OUT OF ANY ASPECT OF SUCH PARTICIPANT'S MEDICAL HISTORY AND MENTAL OR PHYSICAL CONDITION.**

PERSONAL HEALTH HISTORY: To Be Completed by the Participant

This information is essential to enable us to fully address the needs of individual participants throughout the program. Applicants to the Engineering World Health Institute should know that they are not disqualified for the presence of a mental or physical condition. The goal of this assessment is for the safety of participants within the constraints of available resources at the destination. We appreciate and expect, therefore, that individuals will fully disclose any relevant records of his or her mental health.

NAME & ADDRESS (Participant)

Last Name First Name Date of Birth Sex

Number & Street

City State/Territory Zip Country

NAME & ADDRESS (Parent/Guardian/Emergency Contact #1)*

Last Name First Name Phone Number

Number & Street

City State/Territory Zip Country

NAME & ADDRESS (Parent/Guardian/Emergency Contact #2)*

Last Name First Name Phone Number

Number & Street

City State/Territory Zip Country

*Parent/Guardian information is only required if the participant is not of majority age in their state/country. If you are of majority age in your state/country, providing this information is encouraged but not mandated.

HEALTH HISTORY (Check "Yes" or "No" and give dates for all "Yes" answers)

	Y	N	Date		Y	N	Date		Y	N	Date
Asthma				Eye Trouble				Pneumonia			
Bronchitis				Fainting				Poliomyelitis			
Cancer				Frequent Colds				Poison Ivy			
Chicken Pox				Headaches				Rheumatic Fever			
Convulsions				Heart Trouble				Scarlet Fever			
Diabetes				Kidney Trouble				Sleep Walking			
Dizziness				Measles				Thyroid Disorder			
Ear Infections				Mononucleosis				Tuberculosis			
Epilepsy				Mumps							

Allergies	**Y**	**N**	**Events**	**Y**	**N**	**Date**
Hay Fever			Accidents			
Insect Stings			Operations			
Penicillin			Pregnancy			
Other:			Other:		Other:	

1. Please give all details concerning any disease or allergy to which "Yes" is answered previously, including names and addresses of physicians and hospitals.

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2. Have you suffered: any chronic or recurring illness, tuberculosis, epilepsy, heart disease, asthma, diabetes, or any other diseases?

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If yes, give details, including names and addresses of physicians and hospitals and furnish specialist's letter.

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3. Have you undergone any operations or sustained any serious injuries? __________________

   If yes, give details, including names and addresses of physicians and hospitals.

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4. Are you taking any medications? Please state the full pharmacological name and condition it is treating.

____

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____

5. Is there anything regarding your physical and mental health that your On-the-Ground-Coordinator should be aware of in order to assist you to be productive and have a good experience on this program?

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____

____

INSURANCE POLICY INFORMATION

Note: This section of the medical form is not applicable to all participants. If you are in a country where you are covered under public healthcare, simply write "covered by public health care" here, and move on to the next page. If you have a travel health insurance policy (not required), you may include that information here.

Are you covered by health insurance? YES NO

Policy Holder's Name:____________________________ Policy Holder's Date of Birth:________________

Address:____ Relationship to Participant:____________

City, State/Territory, ZIP, Country:____

Occupation:____

Employer's Name:____

Employer's Address:____

Insurance Company Name:____

Insurance Company Address:____

Member #:______________________ Group #:______________________ Plan Type:_________________

I certify that I ____________________________________ (participant signature) am insured under the above insurance and that the information is current and accurate. I have verified with my insurance company and/or agent that my health and accident insurance covers me in the place/country where I will be participating in an EWH Institute. I hereby assume responsibility for all medical expenses I incur and all medical expenses incurred on my behalf while I participate in an EWH Institute.

I understand that I must make provisions before departure for the continuation of any medical treatments, the meeting of any special medical or nutritional needs, and the securing of any special services or facilities that I may need during the program. EWH makes no representation with respect to the availability or quality of any medical services or facilities available during participation in Institute programs.

EWH strongly advises all participants to keep their medical insurance policies in good standing and check with their provider regarding coverage outside of their home country. The travel insurance policy provided with program tuition does NOT replace a medical insurance policy.

<u>All above information must be filled out completely and will be treated as strictly confidential.</u>

PHYSICAL EXAMINATION

- To be completed by a licensed medical professional
- *This portion of the form may be substituted with a physical examination form from the physician's office*

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITY
Head	[ ]	[ ]	______________
General Build	[ ]	[ ]	______________
Neck	[ ]	[ ]	______________
Ears	[ ]	[ ]	______________
Eyes	[ ]	[ ]	______________
Teeth	[ ]	[ ]	______________
Mouth, Throat	[ ]	[ ]	______________
Chest, Lungs	[ ]	[ ]	______________
Heart	[ ]	[ ]	______________
Vascular/BP	[ ]	[ ]	______________
Abdomen, Viscera	[ ]	[ ]	______________
Hernia	[ ]	[ ]	______________
G.I. System	[ ]	[ ]	______________
G.U. System	[ ]	[ ]	______________
Upper Extremities	[ ]	[ ]	______________
Lower Extremities	[ ]	[ ]	______________
Spine	[ ]	[ ]	______________
Skin, Lymphatic	[ ]	[ ]	______________
Nervous System	[ ]	[ ]	______________
Mental State	[ ]	[ ]	______________

Height ____________ Weight ____________

Serological Tests (if known, not required):
Hemoglobin ___________ Blood Type ____________ Rh ___________________________

Date of last vaccination against:

This is a general selection of recommended vaccinations. Engineering World Health does not give medical nor vaccination advice (beyond the "required" section below). Not all of these vaccinations may be required for your program country, nor is this an exhaustive list of vaccinations that may be recommended for your program country. Your physician should be able to give you the best recommendations for vaccinations. Note that for travels to regions where malaria is endemic, prophylaxis is encouraged and should be discussed with your physician.

Hepatitis B _________ Hepatitis A _________ Yellow Fever (Africa only) _________

Typhoid _________ Measles ________ Mumps __________ Rubella _________

Diphtheria ________ Whooping Cough______ Salk (Polio)___________

Required items:

Negative TB Disease Diagnosis*: _________ Tetanus Vaccination**: _________

COVID-19 Vaccination (1): _________ COVID-19 Vaccination (2): _________

COVID-19 Vaccination (Booster)***: _________

*A negative TB disease diagnosis is **required** for working in a healthcare setting. Be sure you don't receive any live vaccines in the 28 days **before** your TB test as they can interfere with the test (MMR, chicken pox, oral typhoid, shingles, or yellow fever vaccines). These vaccines can be given on the same day as the TB test or anytime after the test is completed. Td, Tdap, polio, hepatitis A and B are all inactivated vaccines and can be given anytime before or after the TB test. Your negative TB test results must be from within one year of your program end date.

**Tetanus is a very common and very dangerous bacteria. Given the work environment, all participants are required to have a current tetanus vaccination. Your most recent tetanus vaccination must be less than 10 years before your program end date.

***The CDC currently (September 2023) recommends that all individuals aged 6 years and older receive at least one Pfizer or Moderna booster vaccination. Thus, all EWH travelers must have received at least one booster vaccination prior to the start of their program. A booster vaccination is an additional vaccination that is received after the completion of an initial vaccination series. You will be required to submit proof of vaccination. Please direct questions to summerinstitute@ewh.org.

Which COVID-19 vaccination did the participant receive?

____

Recommendations or comments regarding required vaccinations:

____

____

By executing this Medical Examination Form (the "MEF"), the Participant agrees to indemnify and hold Engineering World Health and its officers, directors, representatives, agents and employees harmless from any liability, loss or damage they may suffer as a result of claims, losses, demands, costs or judgments against them caused by or arising out of a misstatement or omission by Participant in this MEF, the failure of Participant to comply with any of the terms and conditions of the MEF or any of the Participant's obligations set forth in the MEF, or the failure of Participant to accept or adhere to any of the recommendation of EWH set forth in the MEF.

Physician's Statement

I have read the "Notes to the Examining Physician" on pages 1 and 2 and thereafter have examined ___________________ (participant's name) and have recorded the results above which represent to the best of my knowledge, all the participant's medical history and my findings on examination. **In my opinion, the participant is physically and mentally fit to travel and capable of participating in the program as outlined in the Notes**. To the best of my knowledge, the information on pages 7 and 8 are correct. I understand that EWH and their representatives will rely on my above report and findings.

Name:____

Address:____

Phone:______________

Date:_______________

Signature

________________________________ ________________________________

(Signature of Healthcare Provider) (License Number)

Participant Statement, if of majority age

I have read the "Notes to the Examining Physician" on page 1 and particularly items (V), (VI), (VII), (VIII) and (IX). I hereby certify that, to the best of my knowledge, the above medical form is complete in all its details and fully realize that any condition, mental or physical, that I am found to have originating prior to my arrival in my country of participation, and which is not described in full in this form or in any accompanying letter, will be due cause for my return to my country of origin or treatment solely at my expense, and that EWH and their representatives have neither responsibility or liability arising out of such condition. I also realize that medical coverage does not include dental treatment of any form whatsoever, or eyeglasses. All medications that I take regularly are at my own expense, and have been detailed in this form or in letters. I also give my full permission for all treatment of any nature deemed necessary by physicians in the host country to be extended to me within the framework of the Medical Services of EWH representatives. I also acknowledge the fact that usage or involvement with alcoholic beverages, drugs or narcotics or any other antisocial behavior may be cause for immediate dismissal from the EWH Institute, and I will be returned home at my own expense.

Name of Participant:____

Participant Signature:_____________________________________ Date:___________

Parent or Guardian Statement

(if participant is not of majority age)

I hereby certify that the attached Physician's Health Statement was completed by the physician only after examination of the participant, _____________________________.

This is a full and complete statement of the participant's health submitted to you as part of the application for admission to an EWH Institute.

I understand that the medical care provided for participants in the EWH Institute does not include pre-existing conditions (i.e. allergies, asthma, ulcers, previous operations, etc.), eyeglasses, pregnancy or dental treatment of any kind. The attached physician's statement of health states in detail all medications which the participant is required to take regularly, and such medication will be supplied by the participant at their expense.

I understand that if, after arrival in the country of participation, participant becomes ill or unable to participate in the EWH Institute, and such illness or inability is the result of any pre-existing or undisclosed condition of which EWH Institute had no knowledge, participant may not be permitted to continue in the EWH Institute, and any medical treatment will be at their expense. I also understand that if it is decided that the participant should not continue in the EWH Institute, the participant will be returned home at their expense. If, while the participant is in a host country, any medical treatment is needed, I herewith give full permission for all such treatment by physicians in the host country to which the participant may be taken or referred by you.

I acknowledge that the usage of, or involvement with any drugs or narcotics (except those prescribed by a physician for medical treatment), will result in immediate dismissal of the participant from the EWH Institute, and the participant will be responsible for all expenses resulting from such involvement and dismissal.

Name of Participant:____

Parent/Guardian Signature:_____________________________ Date:________________

Relationship to Participant:____