International Internships

Reference Form—Physician/Health Care Professional

Name of Applicant: _____

TO THE APPLICANT: Please complete **Part A** on your own, then review **Part A** and complete **Part B** with your physician. If you have further questions, please call us at 626-398-1010. You may return this form by email at *international.internships@servantpartners.org* or by mail at *Servant Partners P.O. Box 3144, Pomona, CA 91769*. All information is treated confidentially.

Part A: Self-Report (This section to be filled out by the applicant)

Do you have or have you ever had any of the following? If yes, check box and comment below.

PERSONAL HISTORY

- ☐ Anemia
- ☐ Appendectomy
- ☐ Asthma
- ☐ Back Problems
- ☐ Broken Bones
- ☐ Diabetes
- ☐ Dislocation of Joints
- ☐ Ear Trouble
- ☐ Epilepsy
- ☐ Eye Trouble
- ☐ Fainting Spells
- ☐ Gall Bladder Problems
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Intestinal Trouble
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mental or Nervous Disorders
- ☐ Paralysis
- ☐ Recurrent Diarrhea
- ☐ Recurrent Headache
- ☐ Rheumatism/Arthritis
- ☐ Shortness of Breath
- ☐ Skin Conditions
- ☐ Stomach/Duodenal Ulcer
- ☐ Surgery
- ☐ Tonsillectomy
- ☐ Tumor/Cancer
- ☐ Venereal Disease
- ☐ Weakness

ALLERGIES

- ☐ Penicillin
- ☐ Sulphonamides
- ☐ Serum
- ☐ Food Allergies (specify) _____
- ☐ Other Allergies (specify) _____

FEMALES ONLY

- ☐ Excessive Flow
- ☐ Irregular Periods
- ☐ Severe Cramps

Are you pregnant? ☐ Yes ☐ No

FAMILY HISTORY

Have you or any in your family had any of the following?

- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy/Convulsions
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Stomach Disease
- ☐ Tuberculosis

COMMUNICABLE DISEASES

If you have had any of the following, please give dates.

- ☐ Chickenpox Date: _____
- ☐ Scarlet Fever Date: _____
- ☐ Measles (Rubella) Date: _____
- ☐ Tuberculosis (TB) Date: _____
- ☐ Mumps Date: _____
- ☐ Pertussis (Whooping Cough) Date: _____
- ☐ Other (specify): _____ Date: _____

COMMENTS *For any box checked above, please comment here. Use additional pages if necessary.*

SERVANT PARTNERS

International Internships
Reference Form—Physician/Health Care Professional

IMMUNIZATION HISTORY

Immunizations are voluntary and are not included in the program costs. If you choose not to be immunized, please indicate your reasons below. Your decision to forego immunization will not affect your acceptance into the program. **(Note: Some of the immunizations require multiple dosages over a period of time. Please plan accordingly.)**

Please mark the immunizations you will have completed before beginning this program.

☐ Hepatitis A	Date: _____	☐ Poliomyelitis	Date: _____
☐ Hepatitis B	Date: _____	☐ MMR	Date: _____
☐ Typhoid	Date: _____	☐ Japanese Encephalitis	Date: _____
☐ Rabies	Date: _____	☐ Malaria Prevention Medication	Date: _____
☐ Tetanus/Diphtheria	Date: _____		

I will not be completing the above unchecked vaccination(s) for the following reason(s):

Are you presently under a doctor's care for any reason? If yes, please explain:

Are you taking any medications at this time? If yes, please explain:

Do you now or have you ever received any compensation for disability from any source?

Have you ever sought treatment for any sort of mental illness?

Have you ever sought treatment for an eating disorder? If yes, please explain.

SERVANT PARTNERS International Internships

Reference Form—Physician/Health Care Professional

Part B: Physician's Evaluation (This section to be filled out by the physician)

TO THE PHYSICIAN: Please review the information in Part A. Please indicate all conditions that require treatment and notify us of any problems that merit follow-up by health services.

Physician's Name	**Phone**	**Fax**	**Email**	
Office Address		**City**	**State**	**Zip Code**
How long have you known the applicant?				

APPLICANT'S HEALTH INFORMATION *Please check box for any abnormalities in the following systems:*

Height (in inches)		☐ Eyes	☐ Musculoskeletal
Weight (in pounds)		☐ Teeth	☐ Endocrine
Overweight/Underweight?		☐ Neuro-Psychiatric	☐ Lymphatic
Blood Pressure		☐ Cardiovascular	☐ Skin
Color Perception		☐ Respiratory	☐ Head
		☐ Trunk and Back	☐ Ear, Nose, Throat
		☐ Hernia	☐ Pelvic

COMMENTS *For any box checked above, please describe fully.*

PHYSICIAN'S RECOMMENDATION

☐ Acceptable without limitations
☐ Acceptable with limitations (*please specify below*)
☐ Acceptable, but should remain in areas where adequate medical care is provided (*please specify below*)
☐ Not acceptable (*please specify below*)

COMMENTS

Physician's Signature: _____ **Date:** _____

Please return completed form by email, fax or mail:
international.internships@servantpartners.org | 626-398-1010
Servant Partners | P.O. Box 3144 | Pomona, CA 91769