

# *MEDICAL CLEARANCE FORM*

# *Please start your Medical check-up as soon as you have been accepted to go on mission. Particularly the vaccinations may take time to complete and your contract cannot be issued until you have completed the medical examination. This form must be completed by a Registered Medical Doctor together with the person in question.*

***Please write clearly***

*Name:* ……………………………………………………………………………………………

*Male* *Female*

*Nationatlity …………………………………………………………………………………….*

*Present Country of Residence*: ………………………………………………………………..

*Going to:* ……………………….………………………………………………………………..

*Position (for delegates)…………………………………………………………………………*

*For a Period of*: …………… *months*

***Contact Details***

*E-mail*: …………………………………………………………………………………………

*Phone number:* …………………………………………………………………………………

*Please give* ***name, relationship and phone numbers*** *of two persons (e.g spouse/relative/friend) that can be contacted in case of an emergency in the field:*

1. *………………………………………..*…............................................................................

….....................................................................................................................................

1. *…………………………………………..*….........................................................................

….....................................................................................................................................

***Note:*** *If the person has a condition that is likely to be aggravated in the tropics and/or expose the Delegate to increased health risks; the deployment of the person will require extra care in assessing both the individual situation and the level of available healthcare in his/her area of assignment. Such conditions include: Heart or circulatory conditions, renal disease, chronic respiratory disease, chronic skin disease, diabetes, rheumatism, epilepsy, peptic ulcer, colitis, mental and stress disorders, problem with alcohol and severe obesity (BMI > 35).*

***Personal History of Health***

***To be completed by self***

*Name*…………………………………………………………………………………………….

*Date of Birth*……………………………………………………………………………………..

*Have you suffered from any of the following? If “Yes” indicate when.*

*Yes No Year and description*

*Asthma or Bronchitis*   *………………………..*

*Tuberculosis*  *⁪*  *⁪ ………………………..*

*Arthritis*  *⁪*  *⁪ ………………………..*

*High blood pressure*  *⁪*  *⁪ ………………………..*

*Heart and circulatory problems*   *⁪ ………………………..*

*Thrombosis*   *⁪ ………………………..*

*Ulcer of the stomach*  *⁪*  *⁪ ………………………..*

*Liver disease, jaundice*  *⁪*  *⁪ ………………………..*

*Urinary tract disorder/kidney trouble*  *⁪*  *⁪ ………………………..*

*Back problems*  *⁪*  *⁪ ………………………..*

*Skin disease*  *⁪*  *⁪ ………………………..*

*Mental health problems*  *⁪*  *⁪ ………………………..*

*Fainting spells, convulsions*  *⁪*  *⁪ ………………………..*

*Epilepsy*  *⁪*  *⁪ ………………………..*

*Head injury/concussion*  *⁪*  *⁪ ………………………..*

*Other serious accident/injury*  *⁪*  *⁪ ………………………..*

*Surgery*  *⁪*  *⁪ ………………………..*

*Diabetes*  *⁪*  *⁪ ………………………..*

*Malaria*  *⁪*  *⁪ ………………………..*

*Other illnesses (specify)* …………………………………………………………………………

*………………………………………………………………………………………………………*

*Name :…………………………………………………………………………………………………*

*Have you been hospitalised during the last 10 years? Yes*   *No*

*If yes, specify…………………………………………………………………………………………*

*Health problems during previous mission(s) Yes*   *No*

*If yes, specify…………………………………………………………………………………………..*

*Are you presently being treated for any medical condition? (Please indicate the condition and if you take medication)*

*……………………………………………………………………………………………………………*

*……………………………………………………………………………………………………………*

*Please state if you are on any ongoing or temporary medication*

*……………………………………………………………………………………………………………*

*Please list any allergies that you have and your reaction if you are exposed*

…................................................................................................................................................

…................................................................................................................................................

*Dietary restrictions……………………………………………………………………………………...*

*Have you ever suffered from any condition which prevented travel by air (if yes,specify)*

*……………………………………………………………………………………………………………*

*Are you a regular user of tobacco? Yes*  *No* *No*

*Daily quantity: ……………………… of ………..………….………….for …………………years*

*Consumption of alcohol Yes*   *No*   *Quantity………………………………………...*

*Do you consider yourself to be in good health? Yes*  *No*   *Comments ………………*

*…………………………………………………………………….………………………………….….*

*Family history, such as serious hereditary diseases*

*……………………………………………………………………………………………………...….…*

***Physical Examination to be completed by a medical doctor:***

***Please write clearly***

*Name …………..*………………………………………………………………………………..

*Date of Birth*……………………………………………………………………………………..

*Sex: M*   *F*   *F*

*Height…………………* *cm BodyMassIndex BMI: ………………*

*Weight…………………kg Abdomen ……………………………*

*Blood pressure…..…../…..… mmHg Genital/urinary………………………*

*Pulse….………………r/m Vision WITH or WITHOUT glasses*

*Respiration……………r/m Left…………… Right……………….*

*Lungs………………………… Hearing: Left………… Right……………*

*Heart……………………….. . Dental condition……………………….*

*Skin………………………….. ……………………………………………*

*Ear/Nose/Throat………………………………………………………………………………………*

*Endocrine……………………………………………………………….………………………………*

*Neurological reflexes ……………………………………………………………………………..*

*Chest X-ray and ECG (if >45 yrs or if risk factors are present)*

*Remarks…………………………………………………………………………………………………*

*……………………………………………………………………………………………………………*

***Males:*** *PSA (if >45 years)……………………………………………………………………………*

***Females****: Breast palpation Right…………………………….Left…………………..*

**Pap-smear**………………………………………………………………………………………………

***Laboratory findings:***

***Urine****: Albumin, Glucose, Microscopic………………………………………………………………*

***Stool-test:*** *(if indicated): Blood……… Parasites…………………………………………………*

***Lab-results continued: (Please fax or scan lab-list with results)***

*Red blood cells…….. Glucose …………….*

*Haemoglobin ........... SGPT(ASAT) ………*

*Hematocrit …….. SGOT(ALAT) ………*

*Leukocytes ……… Gamma GT…………*

***Blood group:***

***Rhesus****: POS NEG*

***Diff count:*** *Creatinine ………..*

*Neutrophils …………. Cholesterol …………*

*Lymphocytes …………… HDL ………...*

*Monocytes ………….. LDL …………*

*Eosinophils ………….. ESR …………*

*Basophils …………..* *(Erythrocyte Sedimantation Rate)*

*Thrombocytes…………… CRP ………….*

*Testing for HIV is voluntary. There is no obligation to share the results with anyone, unless you choose to do so. However, the Federation recommends its employees to find out their HIV status for their own benefit and safety. The Federation does not discriminate against people living with HIV.*

*Medical Doctor’s comments and summary of any findings that require follow-up or restrictions in type of mission:*

……………………………………………………………………………………..………..……….......

....................................................................................................................................................

***Conclusion:*** *Mr / Ms …………………………………………………………………………………*

*is mentally and physically* ***FIT*** */* ***UNFIT*** *to go and work/live in the proposed country.*

*Name of examining doctor……………………………………………………………………………..*

*Date……………………….. Place……………………………………………………………………..*

*Signature and stamp……………………………………………………………………………………*

*Telephone or email……………………………………………………………………………………..*

*I, the undersigned, understand that this medical report will be treated confidentially and agree that a copy is sent to the Human Resources, Health Officer in Geneva.*

*Delegate’s Signature…………………………………………………………………………….*

**Strongly recommended vaccinations**

The vaccinations are part of the Medical Clearance. Carefully read through the following list of vaccinations and complete the form. You should start getting vaccinated as soon as you have received confirmation to go on mission. It is your responsibility to obtain/complete all immunizations listed under “Strongly Recommended Vaccines” as well as the “Recommended vaccinations” as advised by the Health Officer in Geneva. You must inform the Health Officer if certain vaccinations are not available in your home country.

NOTE: If you are pregnant or want to become pregnant, discuss vaccinations carefully with your doctor. The two oral live vaccines (**Typhoid and Cholera**) will become ineffective if taken at the same time as using antibiotics and/or anti-malaria tablets.

* **Hepatitis A:**

Positive immunity, date............................. (No immunization needed).

If no immunity, 2 injections spaced 6-12 months. Booster every 15 years.

Date vaccine 1st............................. 2nd............................. Booster......................

* **Hepatitis B:**

Mandatory for health care professionals and strongly recommended for all others.

Positive immunity, date ........................... (No immunization needed)

If no immunity, 3 injections spaced 0-1-6 months – check immunity after 15 years.

If positive, no booster needed.

Date 1st ...................... 2nd ...................... 3rd...................... Booster ….................

* **Tetanus:**

1 injection, booster in adulthood every 10 years.

Fully immunized Yes No Date of booster................................

* **Diphtheria:**

1 injection, often combined with Tetanus vaccine. Booster in adulthood every 10 years.

Date last booster...................................

* **Polio:**

If the person has had the *full course* (3 IPV or 4 OPV- doses) only *one* lifelong booster is recommended if traveling to the few remaining endemic countries.

Full childhood immunization Yes No Date of Booster……………………

* **Typhoid:**

Strongly recommended for field operations or places with inadequate sanitation.

1 injection every 3 years, *or* 1 tablet taken at day 1-3-5 every 2 years.

Date last vaccine...................................

* **Yellow Fever:**

Required for all delegates going to Africa and Latin America. It is required by some countries if a person is coming from an area where yellow fever is endemic. Effective 10 days after the injection, or immediately in the case of a booster dose. Valid for 10 years.

Date last vaccine.............................

* **Seasonal Human Influenza:**  Recommended to all by WHO, even to healthy adults. Note: There are two types, one for the northern, and one for the southern hemisphere.

Date of vaccination ………………………

**Recommended** **vaccinations (depending on location and situation)**

* **Meningitis:** A+C+W 135 +Y: 1 injection + booster every 3 years. Strongly recommended for delegates working in emergency- and refugee situations, especially in Africa.

Date last vaccine...................................

* **Cholera:** 2 doses orally on day 0 and 7. Valid for 2 years. Important in emergency settings and flood operations.

Date of vaccination 1st …………………….. 2nd …………………………

* **Tuberculosis:** Immunity must be checked with Mantoux or PPD test before vaccinating with BCG vaccine. Strongly recommended for delegates going to countries in the former Soviet Union.

Date of test or vaccine...................................

* **Japanese Encephalitis:** 3 inj. spaced on day 0, 7, 28. Booster after 1 year, then booster every 3-4 years. Required for Indonesia, North Korea, Nepal and Vietnam and strongly recommended for long term delegates in Cambodia, Laos, Sri Lanka and Thailand. For other Asian Countries; check WHO’s site for traveller’s health, <http://www.who.int/ith/en/> or ask the Health officer in Geneva.

Date vaccine 1st ……………… 2nd ………………. 3rd ……………………….

* **Rabies:** 3 inj on day 0, 7, 28 booster after 1 year, then booster every 3 years. Recommended for Nepal, Haiti and Afghanistan.

Date vaccine 1st ........................... 2nd.......................... 3rd.......................

* **Measles:** lifelong immunity. Must be checked before immunization is done. Recommended in emergency / refugee situations.

Date of vaccination: ………………….....

Send pages **1-7** to the Health Officer at the Secretariat in Geneva by Fax to: +41 22 730 49 58, or scanned to the Health officer’s email address: [hannele.haggman@ifrc.org](mailto:hannele.haggman@ifrc.org)

For questions, please contact Hannele Haggman, who will be pleased to help you. Phone: +41 22 730 44 17