**South- North Volunteer Program of Bremen Mission  
Medical Examination Form (for completion by doctor)**

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| Name of applicant: | | | | | |
| Date of birth: | | | | | |
|  | male |  | female |  | divers |

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| How long have you known the applicant? |
| Have you attended him/her professionally?  yes  no  If yes, what complaint? |

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| How is the general condition? |
| Pulse rate: |
| Blood pressure: |
| Result of chest X-ray: |

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| Any family history of disease? |
| Any serious operations, injuries or illness in the past? |
| What infectious diseases has the applicant had? |

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| Any eye defects?  yes  no  If yes, are spectacles worn and satisfactory? |
| Any ear disease?  yes  no  If yes, please specify: |
| Any hearing defect?  yes  no  If yes, please specify: |
| Are mouth and throat healthy?  yes  no  If no, please specify: |
| Are teeth well cared for?  yes  no  If no, please specify: |
| Are heart and lung healthy?  yes  no  If no, please specify: |
| Any abdominal signs or symptoms?  yes  no  If yes, please specify: |

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| Is the applicant vaccinated against the following diseases? | | | |
| Tetanus | yes | no | If yes: When? |
| Diphtheria | yes | no | If yes: When? |
| Pertussis | yes | no | If yes: When? |
| Measles | yes | no | If yes: When? |
| Mumps | yes | no | If yes: When? |
| Rubella | yes | no | If yes: When? |
| Polio | yes | no | If yes: When? |
| Hepatitis | yes | no | If yes: When? |
| Covid-19 | yes | no | If yes: When? |
| **If available, please attach a copy documenting the vaccination status.** | | | |

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| Any signs of hernia? |
| Urine: |
| Any albumen? |
| Any sugar? |
| Any organic, nervous or other disorders? |
| Any functional disorders? |

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| Is the applicant emotionally well balanced?  yes  no  If no, please specify: |
| Is there any history of depression?  yes  no  If yes, please specify: |
| Is there any tendency to depression?  yes  no  If yes, please specify: |
| Do you have any knowledge of the applicant’s life-style and is there any evidence of abuse of alcohol or drugs?  yes  no  If yes, please specify: |
| Do you consider that there are any medical reasons why the applicant should not go abroad for 12 months?  yes  no  If yes, please specify: |

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| Does the applicant need any special diet or regular medical treatment of any kind?   yes  no  If yes, please specify: |

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| Name of examiner: |
| Address of examiner: |
| Date: |
| Signature of examiner |