Diocese of Northwestern Pennsylvania: Mission to Santiago
Physician Certification Form

I examined (first and last name of patient): _____ on (date):_____

HEIGHT: _____ WEIGHT: _____ AGE:_____ RESTING BP:_____ DOB:_____

Specific Medical Information: Side By Side Ministries will take reasonable care to see information remains in confidence.

1. Known allergies (medication, foods, or environment):

   _____

2. Medically prescribed meal plan or dietary restrictions:

   _____

3. Glasses, contacts, or protective eyewear:

   _____

4. Physical limitations:

   _____

5. Current prescribed medications (name, reason, dosage, frequency – please attach additional pages if necessary)

   _____

6. You should be aware of the following medical conditions concerning this patient at present and concise directions for such:

   _____

7. Date of last tetanus/diphtheria immunization:

   _____

8. Other relevant immunization dates:

   _____

9. Is there any reason why this patient should not participate in certain activities relevant to missionary work (heavy lifting, running, sun exposure, etc)?

   _____

Signature of licensed medical personnel: _____

PA or other state license number of examining physician: _____

Printed name: _____ Date: _____

Address:_____

Phone: _____