Dharma Realm Buddhist Association

The City of Ten Thousand Buddhas

4951 BODHI WAY, CA 95482, U.S.A. TEL: (707) 462-0939 FAX: (707) 462-0949

GENERAL HEALTH &TUBERCULOSIS CLEARANCE FORM

Instructions: **Section I**: Basic Personal Information - filled out by the participant
Section II: Health and TB screening/clearance form must be performed and signed by a licensed physician within the last 12 months and updated every 4 years.

Please return completed form to CTTB Medical Clinic in one of the following ways:

1) Upload during online registration process
2) Email: cttbclinic@drba.org
3) Mailing Address: CTTB Clinic – Attention Donna Farmer, 4951 Bodhi Way, Ukiah, CA 95482

Confidential Medical Information

Section I – filled out by participant

Name _____
Last First Middle

Country of current residence _____

Birth Date _____/_____ /_____ Gender ____Female ____Male
Month Date Year

Emergency Contact: Name _____relation_____Phone_____

Medical Insurance/Travel Insurance Company _____Policy #_____

Have you traveled abroad in the past month? Where?_____

SECTION II - filled out by physician

GENERAL HEALTH CONDITIONS

Any significant past medical history __ No __Yes Specify_____

Allergy (medication, food, and others) __ No __Yes Specify _____

Current Medications __No __ Yes Specify _____

Wheel chair requirement ___No ____Yes

Any other special needs ___ No ___Yes Specify _____

Any history and current psychiatric condition(s)

___No

___ Yes ___depression ___anxiety ___bipolar
___PTSD __ schizophrenia
___psychosis/hallucination
___ Other _____

TB CLEARANCE

Prior TB History

Vaccinated with BCG ____No ___ Yes
Treated for latent TB infection ____No ___ Yes date of completion _____
Prior TB disease ____No ___ Yes date _____

Evaluation of signs and symptoms

___ No symptoms Date _____

___ Symptoms (check all that apply)

__ persistent cough ___ unexplained weight loss
__ unexplained fatigue ___ unexplained night sweats
__ unexplained fever ___ loss of appetite

Evidence of TB Clearance

Mantoux PPD Date Given ___/____/____ Date Read ____/____/____ Results ____mm
TB Blood Test Date Given ___/____/____ Results_____
Chest X-ray Date Given ___/___ /____ Results_____
Additional Testing and Results_____Date_____

***Medically cleared of TB ___ YES ___ NO Comments _____**

Name of Physician (Print) _____

License#_____ State/Country _____

Signature_____Date _____

Address_____Phone_____