



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 _____