

# **OMS International** **Physician's Release Form**

OMS International, Inc.  
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Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Complete address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**TO BE ANSWERED BY THE PATIENT:**

List all hospitalizations in the past five years and reasons for such hospitalization: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For what reasons have you missed work in the past two years: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been refused life or health insurance? Yes No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been rejected for military service? Yes No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE DOCTOR:**

Please answer the following questions:

Blood Pressure: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Any restrictions on activities? Yes No

If yes, will they interfere with overseas travel and in what ways? Yes No If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this patient undergoing medical care at this time? Yes No

If yes, would emergency hospitalization be necessary in the event the patient did not maintain his/her present level (which is assumed to be satisfactory) of response to the medical care? Yes No If yes, please explain: \_\_\_\_\_

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Describe any medical conditions of which an attending medical doctor should be aware: \_\_\_\_\_

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Does this patient have any physical, mental, neurological or psychological conditions? Yes No If yes, please explain: \_\_\_\_\_

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Date of last medical examination: \_\_\_\_\_

What medications is the patient taking and for what purpose? \_\_\_\_\_

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Does the patient have a copy of all prescriptions and their side effects that he/she will need during his/her overseas travel? Yes No

Please list any vaccinations recommended or given for this patient's overseas service: \_\_\_\_\_

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A copy of the OMS Medical Release Form for this patient has been provided for my records.

Doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_