FORM 4

CONFIDENTIAL MEDICAL QUESTIONNAIRE

TO BE COMPLETED BY THE DOCTOR. FOR BACKGROUND, PROVIDE THE DOCTOR WITH FORM 2.

APPLICANT NAME	

The client is applying for the ***iALA*** program. Taking part in this program demands a high level of emotional and physical fitness. By assessing the client and completing a fit to proceed report, you support acceptance of the client into the ***iALA*** program.

Blood pressure	
Heart rate (in rest)	
Weight	
Length	
Blood type	

Please send this form directly to:

Name J. Heenop

Address P.O. Box 570, Stilbaai 6674

Cell 082 455 8745

Fax 086 766 3003

E-mail iala@admineve.co.za

	EXCELLENT	GOOD	OKAY	BAD
Visual ability (without glasses or contact lenses)				
Visual ability (with glasses or contact lenses)				
Hearing				

IN YOUR OPINION, WOULD THE CLIENT BE ABLE TO	YES	NO
Hike for 5 days, 20km per day?		
Scuba dive?		
Do you agree on the physical self-report of the client?		

CONFIDENTIAL MEDICAL
QUESTIONNAIRE

Any allergies, chronic or other disease, or regular medication that iALA should know of?

Please provide any additional information which, in your opinion, **iALA** should have knowledge of, to meet the student's best interest, on a separate sheet of paper with the name of the student above.

FINAL FEEDBACK FROM PHYSICIAN			
Accept without any limitations		Do not accept at all	
Accept with limitations		Applicant requires medical and social support during the course of the year	

DETAILS OF PHYSICIAN		
Name		
Address		
Contact number		
May we contact you telephonically if need be?	YES NO	
Signature	Date	