Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____ Medical Case Number:_____
(Mo/Day/Year)

Asthma Evaluation Form
OMB No.: 0420-0550
Expiration Date: 1/31/2014

ASTHMA EVALUATION FORM

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported having Asthma. This form must be completed by the Health Care Provider (MD or DO as required by State law) who provides, or provided, medical oversight and management of this health condition.

Note to the Provider: Please be candid when answering the questions below. During Peace Corps service, a Volunteer may be placed in a site that requires flexibility and physical endurance to adapt to unpredictable housing conditions, climate extremes, and unreliable transportation and to exhibit a heightened awareness for personal safety and increased attention to safe food and drinking water. Walking long distances on rough terrain is not uncommon. There may also be limited access to Western-trained health professionals and medical care. The most accurate representation of this condition is critical for the Peace Corps to make appropriate decisions for placement of the Volunteer. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

Privacy Act Notice

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq. It will be used primarily for the purpose of determining your eligibility for Peace Corps service and, if you are invited to serve as a Peace Corps Volunteer, for the purpose of providing you with medical care during your Peace Corps service. Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Peace Corps Volunteer.

This information may be used for the purposes described in the Privacy Act, 5 USC 552a, including the routine uses listed in the Peace Corps' System of Records. Among other uses, this information may be used by those Peace Corps staff members who have a need for such information in the performance of their duties. It may also be disclosed to the Office of Workers' Compensation Programs in the Department of Labor in connection with claims under the Federal Employees' Compensation Act and, when necessary, to a physician, psychiatrist, clinical psychologist or other medical personnel treating you or involved in your treatment or care. A full list of routine uses for this information can be found on the Peace Corps website at http://multimedia.peacecorps.gov/multimedia/pdf/policies/systemofrecords.pdf.

Burden Statement:

Public reporting burden for this collection of information is estimated to average of 75 minutes per applicant and 30 minutes per physician per response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC 20526, ATTN: PRA (0420 - 0550). Do not return the completed form to this address.

Medical Case Number: _____

I. Symptoms:

☐ Wheezing ☐ Cough ☐ Shortness of breath

☐ Chest tightness ☐ Increased sputum ☐ Exertional fatigue

☐ Other: _____

Date the patient first experienced symptoms: _____ Date of *most recent* symptoms: _____

To what degree do these symptoms interfere with activity level or work?

☐ None ☐ Seldom ☐ Frequently

Explanation of above: _____

_____

II. Indicators of Control:

Has this applicant experienced any of the following within the past five years?

☐ Yes ☐ No Nocturnal awakenings Explanation _____

☐ Yes ☐ No Increased need of short-acting beta2-agonists Explanation _____

☐ Yes ☐ No Urgent care/ER visits Explanation _____

☐ Yes ☐ No Life-threatening exacerbations Explanation _____

(attach discharge summary)

Smoking history: _____

_____

III. Provocative Factors *(triggers)*:

☐ Exercise ☐ House dust-mites ☐ Foods ☐ OTHER: _____

☐ Animal dander ☐ Mold ☐ Weather Please provide details for each factor checked: _____

☐ Menses ☐ Viral infection ☐ Pollen _____

☐ Emotional stress ☐ Smoke (tobacco/wood) _____

IV. Classification *(please check one of the following categories)*:

☐ Bronchospasm ☐ Exercise-Induced Asthma ☐ Asthma

If this applicant is classified as having Asthma, please indicate the level of severity: _____

Classification of Asthma Severity*

Check Which Level of Severity Applies	Level of Severity	Days w/Sxs	Nights w/Sxs	FEV1	PEF variability
☐	Mild Intermittent	<2/wk	<2/mo	>80%	<20%
☐	Mild Persistent	3-6/wk	3-4/mo	>80%	20-30%
☐	Moderate Persistent	daily	>5/mo	>60%- <80%	>30%
☐	Severe Persistent	continual	frequent	<60%	>30%

*National Asthma Education Program, Expert Panel Report "Guidelines for the Diagnosis and Management of Asthma," NIH publication No. 98-4051. 7/97

Medical Case Number: _____

V. Treatment within the past five years (please complete table below):

Name of Medication	Dose	Date(s) Started	Date(s)Finished	# of doses per/mo
Over-the-counter inhalers, e,g. Primatene Mist				
Short Acting Beta2 Agonists – inhalers, e.g., Proventil, Ventolin, Maxair				
Long Acting Beta2 Agonists – inhalers, e.g., Serevent				
Corticosteroids – inhalers, e.g., Azmacort, Flovent, Vanceril				
Corticosteroids – oral/injectable, e.g., Cortisone, Prednisone				
Nebulized inhalers, e.g., Provental, Atrovent, Intal				
Non-Steroidal Anti-Inflammatory Agents – inhalers, e.g.,Tilade, Intal				
Methylxanthines – oral, e.g., Theophylline				
Leukotriene modifiers, e.g., Accolate, Singulair				
Immunotherapy (allergy shots)				
Other				

Has the applicant ever experienced a more severe form of Asthma? ☐ Yes ☐ No

If yes, when?_____

Please describe the optimal asthma management plan for this patient (if different from above regimen): _____

_____

_____

_____

VI. Patient Management:

Does the applicant have a good understanding of his/her respiratory condition?

☐ Yes ☐ No Explanation:_____

Can the applicant self-manage daily medications and exacerbations?

☐ Yes ☐ No Explanation:_____

Does this applicant own and know how to use a Peak Flow Meter?

☐ Yes ☐ No Explanation:_____

Does the applicant have any functional limitations or restrictions due to this condition?

☐ Yes ☐ No

If "Yes" is marked, describe limitations or restrictions: _____

_____

_____

_____

Medical Case Number:

What specific recommendations for medical care do you have regarding the management for this condition over the next three years? **All recommendations will help determine the Volunteer's country and site placement**_____

_____

_____

_____

_____

Do you have any concerns that would prevent this applicant from completing 27 months of Peace Corps service without disruption because of the applicant's respiratory condition? **NOTE: Peace Corps Volunteers may serve in isolated areas or areas with limited access to Western-trained health care providers and systems. Please check one box below.**

☐ I have no concerns. This applicant, with regard to Asthma, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided the above recommendations for asthma can be accommodated.

☐ I am unsure that this applicant can complete 27 months of uninterrupted Peace Corps service due to Asthma. I recommend a period of stabilization for this condition and an updated assessment at a future date. Describe and include the length of time for stabilization: _____

_____

_____

☐ I do not believe this applicant can complete 27 months of Peace Corps service without undue disruption due to Asthma.

I certify this information is, in my opinion, an accurate representation of the baseline status of Asthma for the applicant listed above.

Physician Signature/Title (MD or DO as required by state law)_____

Physician Name (Print)_____

Date_____Physician License Number/State _____

Physician Address_____