

Applicant Name _____
(Last, First, Middle Initial)

Date of Birth _____
(Month/Day/Year)

Asthma Evaluation Form
OMB No.: 0420-0550
Expiration Date: 00/00/0000

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 laws) who provides, or provided, medical oversight and management of this health condition.

Considerations for health-care provider:

- Your patient has applied to serve as a Peace Corps Volunteer. During Peace Corps service, most Peace Corps Volunteers face dramatic changes to living conditions, diet, and level of physical activity. Furthermore, they typically serve in remote and resource-limited environments where they are expected to live and work in conditions that parallel those in their local community. It is not uncommon for Volunteers to need to be able to use squat toilets, ambulate for miles on uneven terrain daily, haul water over some distance, and sleep on bedding that does not meet typical US comfort standards. Additionally, they may face unpredictable housing conditions, extremes of climate, unreliable transportation, the need for heightened awareness of personal safety, and increased attention to safe food and drinking water.
- When Volunteers serve with the Peace Corps, the Office of Health Services providers assume primary responsibility for their medical care during the duration of their service. However, it must be recognized that given the resource limitations of countries in which Volunteers serve, there may be limited access to Western trained health professionals. Medical care and resources comparable to U.S. health-care standards are limited and, in the case of specialty physicians, are mostly non-existent.
- In order to help the Peace Corps fully and accurately understand the current health of potential Volunteers and assess whether the Peace Corps can appropriately support and accommodate individualized health care and support needs of your patient, we ask you to review the issues below with your patient and provide us with your written assessment of your patient's medical conditions, functional limitations, and anticipated support needs.

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 service 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 or failure to disclose relevant information may 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 U.S.C. 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, licensed clinical social worker 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 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 complete form to this address.



I. Symptoms

Wheezing Cough Shortness of breath

Chest tightness Increased septum 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*?

Nocturnal awakenings Yes No Explanation: _____

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

Use of systemic steroids Yes No Explanation: _____

Urgent care/ER visits Yes No Explanation: _____

Life-threatening exacerbations Yes No Explanation: _____

Smoking history: _____

III. Specific triggers

IV. Classification (please check on of the following categories)

Bronchospasm Exercise-induced asthma Asthma

If this applicant is classified as having Asthma, please indicate the level of severity below **and provide recent spirometry results, if available.**

Classification of Asthma Severity*

Check Which Level of Severity Applies	Level of severity	Days w/Sxs	Nights w/Sxs	FEV1	PEF variability
<input type="checkbox"/>	Mild intermittent	<2/wk	<2/mo	>80%	<20%
<input type="checkbox"/>	Mild persistent	3-6/wk	3-4/mo	>80%	20-30%
<input type="checkbox"/>	Moderate persistent	daily	>5/mo	>60-<80%	>30%
<input type="checkbox"/>	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



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

Name of Medication	Dose	Date(s) started	Date(s) finished	Doses per/mo
Over-the-counter inhalers				
Short-acting beta2 agonists — inhalers				
Nebulized beta2 agonists (not supported in Peace Corps)				
Long-acting beta2 agonists — inhalers				
Inhaled corticosteroids				
Combination steroid/long-acting beta agonist				
Oral/parenteral corticosteroids				
Methylxanthines — oral				
Leukotriene modifiers				
Anticholinergic — inhalers				
IgE blocker				
Immunotherapy				
Other				



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

Within the last 5 years, has the applicant experienced a more severe episode of asthma? Yes No

If yes, when? _____

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: _____

Document baseline peak flow reading: _____

Does the applicant have any functional limitations or restriction due to this condition? Yes No

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

What other 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.**

Closing signatures

Provider Signature/Title _____

Provider Name (Print) _____ Date _____

Provider License Number/State _____

Provider Address and Phone Number _____

If evaluation completed by other than MD, DO, or NP licensed to practice independently, must be signed or co-signed by a licensed MD or DO.

Co-signature, if required in your state _____

License Number _____

