THE PROGRAM OF DIACONATE FORMATION

DIOCESE OF BUFFALO

MEDICAL RECORD

Name of Candidate: _____

Person to be notified in an emergency:

Name: _____

Relationship: _____

Address: _____

City/State/Zip: _____

Cell Number: _____

Personal or Family Physician:

Name: _____

Address: _____

City/State/Zip: _____

Office Number: _____

Describe your physical health: _____

_____

_____

_____

Indicate any regular use of prescription drugs: _____

_____

_____

Have you had any kind of counseling for emotional stress, nervous conditions, personality, or character disorder? Y. / N

If yes, explain: _____

_____

Do you Smoke? Yes / No.

Do you consume alcohol? Yes / No / Stopped

Have you ever used drugs of any kind? Yes / No

Were you ever enrolled in a substance abuse program? Yes / N

Diocese of Buffalo
795 Min Street
Buffalo, NY 14203

ASPIRANT / CANDIDATE APPLICANT'S MEDICAL STATEMENT

Diaconal training and ministry can be physically, and mentally demanding, and diaconal aspirants and candidates must have sufficient stamina to meet the requirements of their training and vocation. These requirements are similar to those encountered in a standard office-based work week (including extended periods of sitting and standing) but, may also include out of town travel for brief periods and interacting with people in emotionally challenging situations. Training and ministry can also involve working closely with individuals or groups of people; visiting the sick in hospitals and nursing homes; ministering in jails and prisons; and interacting with individuals suffering from psychological impairment or illness. As such, every man enrolled in the Diocese's Diaconal Formation Program is required to have a statement from their physician regarding their health status in relation to their fitness for, and ability to participate in diaconal training and ministry and proof of vaccinations to protect the vulnerable and oneself.

I agree to provide to the Diocese of Buffalo a physician's statement regarding my physical and mental fitness.

Applicants Name: (please print or type): _____

Date of Birth: _____

Signature: _____

Date: _____

PHYSICIAN'S STATEMENT

1. Does the applicant have any physical or mental problems preventing them from participating in diaconal training or ministry as described above?
   YES ____ NO ____
2. Is this applicant under care for any active physical or mental health problems? If yes, are these problems stable and considered under good control? *(attach explanation)*
   YES ____ NO ____
3. Are all immunizations up to date? *(note, especially for any communicable diseases that may be a concern relative to ministerial activities described above)*
   YES ____ NO ____ - See additional form for proof of Vaccinations.
4. Does the applicant have any communicable diseases? If so, please indicate on separate attachment.
   YES ____ NO ____
5. Is the applicant receiving treatment for any psychiatric illness?
   YES ____ NO ____
6. Is the applicant receiving treatment for cancer?
   YES ____ NO ____
7. Has the applicant had any diseases or treatments which might render them immunocompromised?

YES ____ NO ____

8. Does the patient have any physical or mental conditions preventing them from working an eight-hour day?
   YES ____ NO ____
9. Does the applicant have any conditions preventing them from traveling?
   YES ____ NO ____
10. Does the applicant have any conditions that may prevent them from sitting or standing for more than an hour at a time?
   YES ____ NO ____
11. Does the applicant have any history of drug or alcohol abuse?
   YES ____ NO ____
12. Are you aware of the applicant having any history of driving while impaired or in a "blacked out" condition?
   YES ____ NO ____
13. In your professional opinion, is the applicant physically and mentally fit for diaconal training and ministry as described above?
   YES ____ NO ____

Name of Physician (please print)**: _____**

Physician's Signature: _____

Please return this completed and signed form to:

Deacon Timothy Chriswell
Director of Deacons
795 Main Street
Buffalo, NY 14203

IMMUNIZATION REQUIREMENT

New York State Public Health Law 2165 requires all students to demonstrate proof of immunizations. Proof of immunity consists of completing the following information, specifying the type of vaccine and month, day, and year of administration or the date of disease diagnosis, if any, or the date of serologic testing and results, if any. This must then be signed by a physician or health care provider. A student health record from a previously attended school which properly documents the immunization history previously described is also acceptable. THIS INFORMATION MUST BE SUBMITTED BEFORE CLASS ATTENDANCE.

IMMUNIZATION HISTORY

MEASLES REQUIREMENT: For students born on or after January 1, 1957. Two doses of live measles vaccine (administered after 1967). First dose must have been received on or after the first birthday and the second dose received on or after 15 months of age and at least 30 days after the first dose, or physician diagnosis of disease or serologic evidence of immunity. Combined measles, mumps and rubella is recommended for both doses. Individuals born before January 1, 1957 are considered immune.

Date of first dose of live measles vaccine _____

Date of second dose of live measles vaccine _____

Date of disease confirmed by M.D. _____

Immune Titer Report - results and date _____

Born before January 1, 1957 _____

RUBELLA REQUIREMENT: One dose of live rubella vaccine received on or after first birthday or serologic evidence of immunity. CLINICAL DIAGNOSIS OF RUBELLA DISEASE: IS NOT ACCEPTABLE AS PROOF OF IMMUNITY.

Date of vaccine _____

Immune Titer Report - results and date _____

MUMPS REQUIREMENT: One dose of live mumps vaccine received on or after the first birthday or physician's diagnosis of disease, or serologic evidence of immunity.

Date of vaccine_____

Date of disease confirmed by M.D. _____

Immune Titer Report - results and date_____

M.M.R. (MEASLES, MUMPS, RUBELLA): Recommended in place of above individual vaccines and 2 doses required.

Date of Dose 1 - Immunized at 12 months or after _____ Date of Dose 2 - Immunized at or after 15 months and at least 30 days after first date _____

DIPHTHERIA, TETANUS REQUIREMENT: Basic series of 3, or if 10 years have passed since last vaccination, a tetanus/diphtheria booster is required.

Date of complete primary series of tetanus-diphtheria immunizations _____ Date of tetanus-diphtheria booster within the last 10 years _____

POLIO REQUIREMENTS: At least 3 doses of Trivalent Oral Polio Vaccine (TOPV) or 4 doses of Inactivated Polio Vaccine (IPV) or 3 doses of Enhanced Inactivated Polio Vaccine (EIPV)

Date of completed primary series of polio immunization_____ Type of vaccine: TOPV _____IPV_____EIPV_____

Date of last booster: _____

TUBERCULIN SKIN TEST REQUIREMENTS: PPD (mantoux) only within the last 6 months. (Tine or Monovac unacceptable)

Date: _____ Results: Negative___ Positive_____

If positive, chest x-ray is required. Give date and results_____

If BOG vaccine given, PPD required. Date _____ Results: Negative _____ Positive ____

If PPD contraindicated after BOG vaccine, chest x-ray required

Date_____Results_____

HEALTH CARE PROVIDER _____ PRINT NAME_____