HEALTH PROVIDER FORM
FOR SICK, ILL AND INJURED PILGRIM APPLICANT FOR THE 2025 AMS-KOFC WARRIORS TO LOURDES PILGRIMAGE

INSTRUCTIONS

PLEASE NOTE: ALL QUESTIONS MUST BE ANSWERED. **DO NOT** LEAVE ANY BLANK RESPONSES.

The applicant must complete the first two pages of this form prior to seeing the clinician. Your licensed medical provider must complete and sign pages 3 through 11 of this medical evaluation form. **The signed Health Provider Form will be submitted as part of the completed 2025 Application Package no later than January 15, 2025.**

THIS PART TO BE FILLED OUT BY APPLICANT PRIOR TO SEEING THE CLINICIAN

Applicant First Name:

Applicant Last Name:

Applicant Date of Birth: (mm/dd/yyy)

Would applicant be willing to be a medical volunteer throughout the pilgrimage?

☐ Yes ☐ No

If yes, what are applicant's previous medical roles, training, and/or licenses?

Does the applicant speak French?

☐ Yes ☐ No

GENERAL INFORMATION

Please list the Primary Medical Team Member clinicians(s) you are seeing now, and/or have seen recently:

Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:

Please note: one of the above listed clinicians must complete and sign the Health Provider Form. This form will indicate your current health condition(s) and your clinician's assessment of your ability to travel overseas with us on this pilgrimage.

HEALTH PROVIDER FORM (CONT'D)

Applicant First Name: | Applicant Last Name:

Do you take any medications (prescribed / over the counter / supplements)? ☐ Yes ☐ No

If applicable, please list all of your medications and include condition, dosage and schedule. Please attach a listing in this format if additional space is necessary. ***Important note: Medical marijuana is prohibited on any international flight and is illegal in France.***

MEDICATION	CONDITION	DOSAGE	SCHEDULE

Are all your vaccines up to date? ☐ Yes ☐ No

Date of last Tetanus Vaccine/Booster: | Date of last Flu Vaccine:

Date of last COVID-19 Vaccine/Booster:

Do you have any drug allergies? ☐ Yes ☐ No

Specify below (please attach additional information if space is needed.)

Do you have any food allergies? ☐ Yes ☐ No

List below any food allergies and note any dietary requirements or requests.

Have you had any past hospitalizations and/or surgeries? ☐ Yes ☐ No

Specify below (please attach additional information if space is needed.)

PLEASE STOP HERE - A MEDICAL PROVIDER MUST FILL OUT THE REST OF THE EVALUATION

Applicant First Name: _____ Applicant Last Name: _____

DETAILED REVIEW OF SYSTEMS

PLEASE NOTE: A MEDICAL PROVIDER MUST COMPLETE THE REMAINDER OF THIS EVALUATION

1. CARDIOVASCULAR

Problem:

☐ Yes ☐ No

If YES, check all that apply:

☐ Chest pain ☐ Shortness of breath ☐ Palpitations ☐ Swelling of Lower Extremities

☐ Blood pressure ☐ Stroke ☐ Other issues, please specify below.

Specify:

2. RESPIRATORY

Does the applicant use a CPAP?

☐ Yes ☐ No

Problem:

☐ Yes ☐ No

If YES, check all that apply:

☐ Cough ☐ Shortness of Breath ☐ Abnormal Sputum ☐ Sleep Apnea (OSA) ☐ Other issues

Specify:

3. HEARING

Problem:

☐ Yes ☐ No Hearing Aids? ☐ Yes ☐ No

Specify:

Applicant First Name:

Applicant Last Name:

4. VISION

Problem:

☐ Yes ☐ No

Specify:

5. GASTRO-INTESTINAL

Problem:

☐ Yes ☐ No

If YES, check all that apply:

☐ Nausea ☐ Vomiting ☐ Ileostomy ☐ Colostomy

☐ Other issues, please specify below.

Specify:

6. BOWEL FUNCTION

Problem:

☐ Yes ☐ No

If YES, check all that apply:

Constipation:	☐ Frequent	☐ Occasional
Incontinence:	☐ Frequent	☐ Occasional
Diarrhea:	☐ Frequent	☐ Occasional
Level of care:	☐ Self	☐ Physical Assistance

Specify:

Applicant First Name: | Applicant Last Name:

7. URINARY

Problem:

☐ Yes ☐ No

If YES, check all that apply:

Pain	☐ Frequent	☐ Occasional	
Incontinence:	☐ Frequent	☐ Occasional	☐ Bedwetting
Assistive devices:	☐ Catheter	☐ Indwelling	☐ External
Catheter and Indwelling:	☐ Uterostomy	☐ Cystostomy	
Level of care:	☐ Self	☐ Physical Assistance	

Specify:

8. ENDOCRINE

Problem:

☐ Yes ☐ No

If YES, check all that apply:

☐ Diabetes ☐ Thyroid ☐ Other

Specify:

9. NUTRITION

Problem:

☐ Yes ☐ No

Does patient need physical assistance to eat? ☐ Yes ☐ No

Specify:

Food Allergies / Sensitivities:

Level of nutrition care needed (I.e. liquid, pureed, soft-diet):

Applicant First Name: Applicant Last Name:

10. NEUROLOGICAL / ORTHOPEDIC

Problem:
☐ Yes ☐ No

If YES, check all that apply:
☐ Seizures ☐ Headaches ☐ Migraines

Specify:

☐ Ambulatory ☐ Non-ambulatory ☐ Able to stand for transfer

Amputation:
☐ Yes ☐ No

If YES, describe:

Paralysis:
☐ Yes ☐ No

If YES, describe:

Significant limitation of motion:
☐ Yes ☐ No

If YES, describe (I.e. distance, hills, stairs)

Supportive devices:
☐ Bandage ☐ Cast ☐ Brace ☐ Crutches ☐ Walker ☐ Wheelchair

Can individual get on/off the bus without assistance?
☐ Yes ☐ No

Would the patient need a wheelchair while in Lourdes?
☐ Yes ☐ No

WIll the patient require wheelchair service at the airport and during transfers?
☐ Yes ☐ No

Does the patient have osteoporosis, bone weakness or an increased risk of bone fracture?
☐ Yes ☐ No

If YES, describe:

Applicant First Name: Applicant Last Name:

11. HYGIENE / GROOMING

Please indicate level of care needed:

Bathing:

☐ Self ☐ Total Assistance ☐ Partial Assistance

Dressing:

☐ Self ☐ Total Assistance ☐ Partial Assistance

Hair:

☐ Self ☐ Total Assistance ☐ Partial Assistance

Does the applicant have a designated caregiver or aide traveling with him/her?

☐ Yes ☐ No

If YES, will that caregiver or aide also be responsible for giving medication?

☐ Yes ☐ No

12. PSYCHIATRIC

Problem:

☐ Yes ☐ No

If YES, check all that apply:

☐ Anxiety ☐ Depression ☐ Mood Swings ☐ Irritability ☐ PTSD ☐ TBI ☐ Other

Specify:

Current status: (ie controlled with medications):

13. SKIN

Pressure Sores:

☐ Yes ☐ No

Other Problem(s):

☐ Yes ☐ No

If YES, describe:

Applicant First Name: Applicant Last Name:

PHYSICAL EXAMINATION

Height: Weight: Blood Pressure:

Ears:	☐ Normal	
Eyes:	☐ Normal	
Nose:	☐ Normal	
Throat:	☐ Normal	
Lungs:	☐ Normal	
Heart:	☐ Normal	
Abdomen:	☐ Normal	
Genitalia: (optional)	☐ Normal	
Rectal: (optional)	☐ Normal	
Skin:	☐ Normal	
Extremities:	☐ Normal	
Neurological:	☐ Normal	

Other:

Applicant First Name:

Applicant Last Name:

PHYSICAL EXAMINATION CONTINUED...

Diagnois/Diagnoses:

Specific Nursing Care Requirements(s):

Do you understand this patient will be in Lourdes, France, May 13-19, 2025?

☐ Yes ☐ No

Is this patient medically stable to travel to Lourdes, France?

☐ Yes ☐ No

Will this patient require the use of a supplemental oxygen at any time?

☐ Yes ☐ No

If YES, please explain:

Will this patient require the use of any electrical device?

☐ Yes ☐ No

Do you anticipate this patient requiring professional medical/nursing services or hospitalization during travel to/from Lourdes, France, or during the week of the pilgrimage in Lourdes, France?

☐ Yes ☐ No

If YES, please explain:

Applicant First Name:

Applicant Last Name:

Does this individual need to have a service dog traveling with them?

☐ Yes ☐ No

Can this individual sit in a standard coach airline seat for a 9-hour flight?

☐ Yes ☐ No

Does this individual have difficulty walking long distances (approx. 10,000 steps/day with some inclines)?

☐ Yes ☐ No

If applicant does not regularly use a wheelchair and since the pilgrimage can be physically demanding, do you think it would be best for this pilgrim to use a wheelchair while at Lourdes?

☐ Yes ☐ No

Does this individual require single room accommodations for medical reasons?

☐ Yes ☐ No

If YES, please explain:

Does this individual require a handicapped accessible room?

☐ Yes ☐ No

If YES, please explain:

Does the applicant require a Hoyer lift for transfer?

☐ Yes ☐ No

If YES, please explain:

Additional comments:

HEALTH PROVIDER FORM (CONT'D)

Applicant First Name:

Applicant Last Name:

BEFORE SIGNING, PLEASE CONFIRM ALL QUESTIONS HAVE BEEN ANSWERED.

Provider's Name:

Provider's Address:

Provider's Telephone Number (Work):

(Mobile):

(Fax):

Clinician's Email Address:

Signature:

Date:

The official Warriors to Lourdes Medical Director or a member of the Warriors to Lourdes staff may contact you for clarifications on the information provided.

Completed forms can be saved as a PDF and uploaded to your application online. If you're unable to upload your completed medical forms as a PDF, you may send to the Warriors to Lourdes Team at the address below.

THE MEDICAL STAFF HIGHLY RECOMMENDS FOR ALL MEDICAL EQUIPMENT/DEVICES AND MEDICATION TO BE TRANSPORTED IN THE CARRY-ON LUGGAGE.

Knights of Columbus
1 Columbus Plaza
P.O. Box 1966
New Haven, CT 06510
lourdes@kofc.org

WARRIORS TO LOURDES