ACCESS THERAPIES

LATEX ALLERGY PHYSICIAN RELEASE

I_____, do hereby authorize
Traveler Name (please print)
_____, to release to Jasneek Inc. and any of its client hospital or institutions any information relevant to my employment regarding my latex allergy.

_____ _____
(Signature) (Date)

==========

Physician (MD only) to complete below this line

Type of allergy (please check all that apply): _ latex _ powder

Nature of allergy: (please check all that apply):

_____ Irritant contact dermatitis, an external agent directly damages the skin, such as sweating and chafing due to prolonged glove use. Usually manifested as dry, crusty lesions where areas are exposed to latex.
_____ Allergic contact dermatitis (type IV) produces skin lesions or a crusty thickened appearance of the skin. The reaction usually appears some time after exposure, so sensitized individuals may not always associate it with latex gloves. The rash may persist for 7-10 days, and is usually limited to the area where the skin came into contact with the latex. May also include contact pruritus, erythema, vesicular lesions, eczema and contact urticaria.
_____ IgE-mediated hypersensitivity (type I) immediate reactions within 30 minutes to 1 hour from exposure which may affect the skin, upper respiratory tract, lower respiratory tract or gastrointestinal tract. Skin manifestations include flushing, swelling and contact urticaria. Other manifestations are runny eyes and nose, symptoms of asthma, especially expiratory wheezing, diarrhea and/or vomiting.

Exposure limits: (check all that apply)

_____ direct contact _____ environmental

Accommodations: (Please describe in detail any special accommodations that are needed.)
_____
_____
_____
Limitations: (Please describe in detail.)
_____
_____

PHYSICIAN'S STATEMENT

I have examined the individual named above, and to the best of my knowledge, he/she is able to function in his/her profession as a healthcare traveler, with the above listed accommodations and limitations.

_____ _____
(Signature of MD) (Date)
_____ _____
Printed Name (MD) (Date of Examination)

Access Therapies
Suite B
8590 Georgetown Rd,
Indianapolis, IN 46268
P: (317) 876-3963
F: (317) 876-6754