HOPE OF AFRICA

http://www.hopeofafricayouth.com

Volunteer Medical Information Form

Participant Information

Name _____ Date of Birth_____
(As shown on passport) (Month/Day/Year)

Address _____

City _____ State _____ Postal Code _____

Home Phone Number _____Business Phone Number _____

Doctor's Name_____ Phone Number_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____

Home Phone Number _____ Business Phone Number _____

Relationship _____

Medical Information

Have you ever had or do have any of the following:

	YES	NO		YES	NO
Recurrent Headaches	☁	☁	Allergy: Bee Stings*	☁	☁
Epilepsy	☁	☁	Allergy: Penicillin	☁	☁
Fainting Spells	☁	☁	Allergy: Sulfonamides	☁	☁
Asthma	☁	☁	Allergy: Serum	☁	☁
High Blood Pressure	☁	☁	Allergy: Food (specify)	☁	☁
Low Blood Pressure	☁	☁	Heart Trouble	☁	☁
Tumor/Cancer	☁	☁	Rheumatism/Arthritis	☁	☁
Diabetes	☁	☁	Anemia	☁	☁

*If you have allergies you must bring your own up-to-date reaction kit/epinephrine auto-injector

If you answered YES to any of the above questions, please explain: _____

Do you have ANY medical conditions that a medical professional on the trip should be aware of? YES NO

If YES, please explain _____

_____

Are you at present under a doctor's care for any condition? YES NO

If YES, please explain _____

_____

Are you taking any medication at this time? YES NO

If YES, please specify _____

_____

Are you bringing an adequate supply? YES NO

List any phobias that you may have (heights, small spaces etc.) _____

Health Care/Insurance # _____ Insurance Company _____

Phone Number of Insurance Company _____ Contact Name _____

My policy requires that my insurance company be contacted before any treatment is given.
YES NO

Patient's Signature

I certify that the information on the front of this form is accurate. I understand that certain medical conditions may preclude acceptance. All required immunizations must be completed before departure. I realize that I must cover the financial costs of any immunizations that I need.

_____ _____
Participant Signature Date

If yes, to any of the above conditions, besides basic allergies, please consult your physician for any additional needs you may have while traveling.

For Your Physician

Patient's name: _____

I hereby affirm, after my health assessment and review of above information, that my patient,

_____ (full name) on _____(date) has no health limitations that would prevent their participation with a mission trip to Africa. My patient has requested guidance on anti-malarial medication that will suit their needs. Finally, I confirm patient's blood type as listed above.

Physician's Signature_____

Physician's Printed Name: _____

Date_____

Any further comments: