THE HOPE OF AFRICA

http://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

For Your Physician

Patient's name: _____

Blood type: _____

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: