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Medical Form for International Volunteers

1. Name of Volunteer: ______________________ **Date of Birth:** ____________
(dd/mm/yy)

2. Immunizations ***(Include date of last immunization for each disease checked)***

DISEASE		DATE	DISEASE		DATE
Diphtheria	☐	____________	Whooping Cough	☐	____________
Small Pox	☐	____________	Polio	☐	____________
Measles	☐	____________	Yellow Fever	☐	____________
Tetanus	☐	____________	Typhoid Fever	☐	____________

Other: ______________________________________

3. Illnesses (*Check if Yes and indicate when and explain below*)

Illness		Date	Illness		Date
Bleeding Gums	Yes ☐	____________ ___	Colitis	Yes ☐	____________ ___
Heart Disorder	Yes ☐	____________ ___	Epilepsy	Yes ☐	____________ ___
Psychiatric Illness	Yes ☐	____________ ___	Cancer	Yes ☐	____________ ___
Skin Disease	Yes ☐	____________ ___	Diabetes	Yes ☐	____________ ___
Migraine/ Headache	Yes ☐	______________	Ulcers	Yes ☐	____________ ___
High Blood Pressure	Yes ☐	______________	HIV/AIDS	Yes ☐	____________ ___
Alcoholism/ Drug Use	Yes ☐	______________	Hepatitis	Yes ☐	____________ ___
Infectious Disease	Yes ☐	____________	Asthma	Yes ☐	____________ ___

Other: ____

Explain any of the above: ____
____
____
____

4. Injuries (*Check if yes. Indicate when and explain below*)

Injury		Date	Injury		Date
Head Injury	Yes ☐	______________	Back Injury	Yes ☐	______________
Recurrent Ankle Injury	Yes ☐	______________	Broken Bones	Yes ☐	______________
Recurrent Knee Injury	Yes ☐	______________	Other: ______________		

Explain any of the above or any special physical limitations: ______________________
____
____
____

5. **Allergic Reactions:** ***Do you have any allergies, including reactions to food, penicillin, antibiotics, and any other medications?***
Yes ☐ No ☐
If yes, please explain: ____

6. Dietary Needs: ***Do you have any special dietary needs?***
Yes ☐ No ☐
If yes, please explain: ____

7. Surgery: ***Have you ever undergone surgery for any reason?***
Yes ☐ No ☐
If yes, please explain: ____

8. Dental: ***Do you have any problems?***
Yes ☐ No ☐
If yes, please explain: ____

9. Medications (*Please list all the current medications you take. Include the name and the condition being treated.*).