Timor Leste Mission Trip Volunteer Medical Form

Confidential

(Please *print* all responses)

NAME: _____ **D.O.B:** ___/___/_____ **Male** ☐ **Female** ☐

Emergency Contact:

Name: _____ **Relationship:** _____

Address: _____

Phone: (Home) _____ (Work): _____ (Mobile): _____

Travel Insurance details: _____

MEDICAL HISTORY

1. Do you suffer from any form of ASTHMA? NO ☐ YES ☐ - complete Asthma Management Form
2. Do you suffer from any ALLERGIES? NO ☐ YES ☐ - complete Allergy Management Form
3. Do you have any of the following conditions?:

Heart condition of any kind	NO ☐	YES ☐	Migraine headaches	NO ☐	YES ☐
Diabetes	NO ☐	YES ☐	Sight/Hearing impairment	NO ☐	YES ☐
Epilepsy	NO ☐	YES ☐	Joint/ Muscular problems	NO ☐	YES ☐
Bleeding disorder	NO ☐	YES ☐	Other conditions (detail below)	NO ☐	YES ☐
Psychological conditions	NO ☐	YES ☐			

4. Have you suffered any serious injuries in the last 12 months? NO ☐ YES ☐
5. Are you currently on any medications? NO ☐ YES ☐

Please provide complete details for any questions to which the answer is YES (Use a separate sheet if necessary):

_____

_____

6. Details of any medical dietary considerations (Report on Allergy Management Form): _____

7. Date of last tetanus injection _____

8. Level of swimming ability: Poor ☐ Average ☐ Strong ☐

Dietary requirements (Circle):

Milk: Dairy/Soy/Almond /Lactose-Free/I don't drink milk

I eat: Chicken/Beef/Fish **Or I am** Vegetarian/Vegan

I eat: Boil eggs/Fried eggs/Tofu

For breakfast, I prefer to eat _____

Other important dietary information _____

Asthma Management

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(Please *print* all responses) Attach Asthma Management Plan if you have one

1. Usual maintenance medical program followed by the asthmatic:

   _____

   Preventer medication _____ Reliever Medication _____

2. Medication and treatment regime to be used during an emergency asthma attack:

   _____

3. List any known asthma trigger factors experienced by the asthmatic:

   _____

4. Have you had any serious complications with your Asthma in the past 12 months? (Please detail)

   _____

   _____

Allergic Reaction Management

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(Please *print* all responses)

MEDICATION REQUIRED TO TREAT ALLERGIC REACTIONS MUST BE BROUGHT ON THE CAMP AND NOTED ON THE MEDICAL FORM.

1. What are you allergic to? _____

2. What are the signs and symptoms of your reaction? _____

   _____

3. What medication or treatment is required for your allergic reaction? _____

   _____

Please complete this section if the volunteer is under the age of 18 and unaccompanied by a parent.

OVER THE COUNTER MEDICATIONS – Approval to Administer

Below is a list of over-the-counter medications that may be offered to your child if they require it. **Due to our geographical location, we request you confirm your permission to do so, for us to best meet medical requirements as they arise.**

Please **tick those** over-the-counter **medications you approve to be administered** as required

- ☐ Panadol
- ☐ Ibuprofen (anti inflammatory eg Nurofen)
- ☐ Cough Lozenges
- ☐ Cold & Flu Tablets/ mixture
- ☐ Ventolin
- ☐ Antihistamine (eg Claratyne)

- I declare that the information provided on this form is complete and correct and that I will notify the mission trip first aid officer of any changes that occur before departure.
- I give permission for this information to be passed on to third party [eg Doctor, Hospital] to facilitate medical treatment in the event of an emergency.
- This information will be carefully disposed of at the end of the mission trip.

Name: _____

Signature: _____ Date: _____