ASAPROSAR INTERNATIONAL VOLUNTEER PROGRAM

MEDICAL UPDATE

NAME _____ AGE _____

ADDRESS _____ BLOOD TYPE _____

CITY, STATE, ZIP _____ PERSONAL PHYSICIAN _____

PHONE _____ PHYSICIAN'S PHONE _____

EMERGENCY CONTACTS (during trip):

NAME, RELATIONSHIP _____ PHONE NUMBER _____

ADDRESS _____ CITY, STATE, ZIP _____

NAME, RELATIONSHIP _____ PHONE NUMBER _____

ADDRESS _____ CITY, STATE, ZIP _____

HEALTH HISTORY:

RATE YOUR HEALTH: ❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR

DESCRIBE ANY MEDICAL LIMITATIONS _____

ALLERGIES: INSECT STINGS, DRUGS, ETC. _____

OTHER CONDITIONS: HEART CONDITION, FREQUENT COLDS, CHRONIC ASTHMA _____

NAME AND DOSAGE OF ANY MEDICATIONS THAT MUST BE TAKEN _____

ANY ACTIVITY RESTRICTIONS?: ❑ NO ❑ YES DESCRIBE: _____

IMMUNIZATIONS (DATES): TETANUS _____ HEPATITIS _____ POLIO_____ TYPHOID_____ OTHER _____

DO YOU HAVE HEALTH INSURANCE? ❑ YES ❑ NO NAME & POLICY #: _____

ADDRESS: _____

Emergency insurance is only secondary. Your medical insurance carrier will be billed for medical charges in the case of illness or injury during a mission related activity.