Medical Health Questionnaire

Name: _____ Gender: ☐Male ☐Female

Birthdate: _____ Age: _____ Blood Type: _____

Date of Last Physical: _____ Date of Last Tetanus: _____

Group: _____ Trip Dates: _____

If you are 60 years old or more please also complete Physician Approval (pg. 37)

Have you purchased the required traveler's insurance for your trip? ☐Yes ☐No
Please provide proof of traveler's insurance to your group leader

Have you ever been diagnosed with Malaria or Dengue Fever? ☐Yes ☐ No
If yes please circle to indicate diagnosed type

Is anyone in your immediate family dealing with a major medical issue while you are in Panama? ☐Yes *(explain)* ☐No

Do you have experience as a medical care giver or certifications in first aid/CPR?
☐Yes *(list)* ☐No

Please describe any chronic medical conditions or major medical events including surgeries:

List any major allergies to food or substances (medications):

List any medications that you will be bringing/taking during the trip:

**********Complete both pages**********

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List any mental health issues that you have been treated for or suffer from:

.

Are there any other medical issues that we should know about as we host you in Panama?

Emergency Contact(s) *minimum of 2 contacts required*

Name : _____ Relation: _____

Phone: _____ Cell:_____

Email: _____ Other: _____

Name : _____ Relation: _____

Phone: _____ Cell:_____

Email: _____ Other: _____

Please sign to attest all information is true and accurate:

X_____ Date: _____

Please Complete and Return to Group Leader

This information will be kept confidential and will be disposed of properly after the end of the trip

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