Personal Health Checklist

This form must be completed by each person who is traveling, and a copy should be brought along on the trip by the Health Point Person.

## Basic information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_

Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Address (city, state, zip):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: (Name and relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail address: \_\_\_\_\_\_\_\_\_\_\_\_

## Travel and Evacuation Insurance Information:

Carrier or Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: (Describe Reaction and management of the reaction. Attach additional sheets if needed)

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Allergies: (insect stings, hay fever, plants, animals, dust, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medications Currently Taking:

Please list all medications (including over the counter or non-prescription drugs) taken routinely or in case of emergency. Bring enough medication to last the entire trip. Keep medications in the original packaging/bottle that identifies the prescribing physician, the name of the medication, dosage, frequency of administration.

1. Do you take take any medication on a routine basis?

□ I do not take any medication on a routine basis OR

□ I take the following medications:

Med #1\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_ Times each day \_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_

Med #2\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_ Times each day \_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_

Med #3\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_ Times each day \_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_

Eyewear: If you wear glasses or contact lenses, Make sure you have an extra pair and sufficient contact solution etc. Contact lenses are often problematic due to weather conditions, dust and poor sanitation. This can make it difficult to keep contact lenses clean and increase the risk of eye infections. Bring a good pair of sunglasses.

## Current/Past Health History:

1. Have you had a recent injury, illness or infectious disease?

□ No

□ Yes:

Please state here:

2. Do you have □ diabetes, □ asthma, □ seizures, □ No

Please state the treatments here:

3. Do you have any psychiatric conditions that may require treatment?

□ No

□ Yes:

Please state here:

4. Any other Health issue someone should be aware of in an emergency?

□ No

□ Yes:

Please state the treatment here:

5. What is your blood type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Tuberculosis Screening

Most Recent TB PPD Skin Test: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Size (mm) \_\_\_\_\_\_\_\_\_\_ Result \_\_\_\_\_\_\_\_

(PPD test should be placed within two years prior to travel and repeated 3 months after return.) If you have had a positive PPD Skin Test in the past, date of your most recent Chest X-ray and result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken treatment for latent TB infection? When? (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization Record:

## Required Immunizations:

DPT/DOPT/DtaP: #1\_\_\_\_\_\_\_\_, #2\_\_\_\_\_\_\_\_, #3 \_\_\_\_\_\_\_\_, #4\_\_\_\_\_\_\_\_, #5\_\_\_\_\_\_\_\_

Td (Tetanus) booster: (should be within the past 7 years): \_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis A: #1\_\_\_\_\_\_\_\_, #2\_\_\_\_\_\_\_\_ (these must be 6 months apart)

MMR (Measles/Mumps/Rubella) #1\_\_\_\_\_\_\_\_, #2\_\_\_\_\_\_\_\_

Polio (oral or injected) #1\_\_\_\_\_\_\_\_\_, #2\_\_\_\_\_\_\_\_\_\_, #3 \_\_\_\_\_\_\_\_, #4\_\_\_\_\_\_\_\_\_

Polio booster: \_\_\_\_\_\_\_\_\_

Yellow Fever (may be required, take your stamped WHO immunization card when you travel): \_\_\_\_\_\_\_\_\_\_\_\_\_

Japanese Encephalitis (may be required, depends on country): \_\_\_\_\_\_\_\_\_\_\_\_\_

## Highly Recommended Immunizations:

Varicella (chickenpox): #1\_\_\_\_\_\_\_\_, #2\_\_\_\_\_\_\_\_ or Date you had the disease\_\_\_\_\_\_\_\_\_

Hepatitis B: #1\_\_\_\_\_\_\_\_\_, #2\_\_\_\_\_\_\_\_\_\_, #3\_\_\_\_\_\_\_\_

\*may do accelerated series, pending approval by health care provider, if unable to complete series before travel.

Typhoid: \_\_\_\_\_\_\_\_\_\_\_\_

Influenza: \_\_\_\_\_\_\_\_

Meningitis: \_\_\_\_\_\_\_\_\_\_

Malaria Prophylaxis (drug, dose, schedule): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of physician or travel clinic nurse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_ Alternative phone: \_\_\_\_\_\_\_\_\_\_\_

## Sign

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Volunteer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_