

Health Insurance Company: _____ Policy No. _____

Address: _____
Street Address City State/Province Zip/Postal

Telephone: (_____) _____ Social Security Number of Policy Holder: _____ - _____ - _____ OR

Insurance ID Number: _____

MEDICAL INFORMATION

A disability will not prevent the consideration of an applicant. However, applicant medical information is important, because some Legacy Institute projects are physically demanding, geographically isolated, and may be unsuitable for an applicant with health considerations, or who might need medications that are not readily available at a project location. **NOTE: Applicant may be asked to have a physical examination.**

DOES APPLICANT HAVE:

1. Any health problem or disabilities that may prevent participation in physically demanding activities? ___Yes ___No

If yes, please explain (attach note if necessary):

2. Any severe allergies (including food / drug / environmental sensitivities)? ___Yes ___No

If yes, please explain (attach note if necessary):

3. Any allergy to MSG (Mono Sodium Glutamate)? ___Yes ___No

If yes, please explain (attach note if necessary):

4. Are you routinely taking any medications (including non-prescription or over-the-counter drugs)? ____ Yes ____ No

If yes, please list all medications below. **IMPORTANT:** International Customs Laws require that prescription medications must be transported in the original packages that clearly indicate: the doctor, dosage, and frequency of administration.

Medication	Dosage	Frequency	Purpose of Medication

5. Please complete the following health history – explain any “yes” answers below. Has the applicant ever had or does the applicant have:

- | | |
|---|--|
| <p>1. A recent injury, illness or infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. A chronic or recurring illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Severe menstrual pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Any eyesight impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Any ear or hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Sinus infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. A speech impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Frequent throat infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Chronic skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Dizziness due to exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Recurring back pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>17. Abnormal blood pressure, chest pain, or heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Heart disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Reoccurring pneumonia?</p> <p>22. Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Disorders of the Nervous System?. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Professional treatment for emotional or mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Any eating disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Special dietary requirements?. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Intestinal disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Chicken Pox? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Measles / German measles? . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Mumps? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|--|

Please note the question number and explain all answers marked Yes (attach note if necessary):

6. Immunizations – fill in the dates for any immunizations the applicant has had:

IMMUNIZATIONS	Date Last Received	IMMUNIZATIONS	Date Last Received
CHICKEN POX		RABIES	
DIPHThERIA		RUBELLA	
DPT		SMALLPOX	
HEPATITIS A OR IMMUNE GLOBULIN/IG		TETANUS	
HEPATITIS B		TENANUS-DIPHThERIA/TD	
MEASLES		TYPHOID	
POLIO		OTHER:	

IMPORTANT: A record of immunizations is for informational purposes. Immunizations **are not** required by Legacy Institute for volunteers. However, some countries do require visitors to be immunized for prevention of specific diseases. Therefore, the applicant is responsible for obtaining all immunizations legally required by countries hosting Legacy projects. (NOTE: Thailand requires NO immunizations at this time).

APPLICANT: I certify that to the best of my knowledge that the information above is correct, and complete, and accurately reflects my medical history and current medical condition.

Signature of applicant: _____ Date: _____