

Date of Arrival		
____ / ____ / ____		
MM	DD	YY

Via International ~ Los Niños, Inc.,
 A California Nonprofit Corporation
 717 Third Avenue, Chula Vista, CA 91910

VOLUNTEER'S MEDICAL INFORMATION

Name: _____ Date of Birth: _____
Print full legal name month day year

1. Pertinent Health History. Circle applicable items and explain below

Frequent sore throat	Yes	No	High blood pressure	Yes	No
Persistent cough	Yes	No	Irregular heartbeat	Yes	No
Asthma	Yes	No	Other Heart conditions	Yes	No
Shortness of breath	Yes	No	Frequent muscle spasms	Yes	No
Fainting spells	Yes	No	Chronic joint dislocations	Yes	No
Seizures	Yes	No	Chronic back problems	Yes	No
Balance problems	Yes	No	Other joint difficulties	Yes	No
Chronic Dizziness	Yes	No	Diabetes	Yes	No
Any other past medical condition for which you received treatment and/or medication	Yes	No	Any other present medical condition for which you are receiving treatment and/or medication	Yes	No

2. Explain any of the items above for which you answered yes: _____

3. Current medications and medical treatments: _____

4. Date of last TETANUS shot: _____
 (You MUST have had one Tetanus shot in the last ten years in order to participate in the program)

5. Allergies:
 a. Have you ever had a systemic allergic reaction to bee stings, food or medicine? Yes No
 b. If yes, what was the precipitating substance? _____
 c. If yes, what was the treatment? _____

NOTE: If you have allergies, please bring your own EpiPen or Bee Sting Kit

6. Health Insurance Information:
 a. Insurance Provider: _____ Member Number: _____
 b. Doctor's Name: _____ Doctor's phone number: _____
NOTE: Contact your Insurance Provider in advance to learn about your out of country coverage & procedures.

7. Emergency Contact information: who should we contact in case of an emergency?
 Name: _____ Relationship to you: _____
 Phone: Home Phone _____ Cell Phone _____
 Work Phone _____ Email of emergency contact person: _____