

MONADNOCK BIBLE CONFERENCE
257 Dublin Rd, PO Box 70, Jaffrey, NH 03452-0070
603-532-8321 Fax 603-532-4277

Haiti Work Team Medical Form

Team # _____ & Dates _____

Required for all persons traveling to Haiti, including adults.

Everyone, please fill out and sign the front and have physician sign back side of this form.

Name _____ Birth Date _____ Sex _____ Age _____
Last First Initial

Parent or Guardian or Spouse _____ Phone () _____

Address _____ City _____ State _____

Zip _____

If not available **in an emergency**, notify:

Name _____ Phone () _____

Address _____ City _____ State _____

Zip _____

In the event I cannot be reached in an Emergency, I hereby give my permission to the physician or hospital selected by the Team Leadership to hospitalize, secure proper treatment for the above mentioned person.

Signature Required by parent or guardian for those under 18. Those over 18 must sign for themselves. (in ink)

SIGNATURE _____

HEALTH HISTORY: (Check - Giving Approximate Dates)

Diabetes _____ Hay Fever _____ Insect Stings _____ Hepatitis _____

Asthma _____ Ivy Poisoning _____ Seizures/convulsions _____ HIV Positive _____

Depression _____

Known Allergies: _____

Special diet: _____

Operations or serious injuries (Dates) _____

Chronic or recurring illness: _____

Other diseases or details of above _____

Any specific activities to be restricted?

Team members who go to Haiti are responsible for their own medications. We do not provide a nurse and we do not administer prescription medications. All Team Members are required to remember to take their own medications.

Our leadership should be aware of medications taken. Please fill in the following.

<i>Name of Medication</i>	<i>Dosage</i>	<i>Condition medication is to be taken for</i>	<i>Times normally taken</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prescriptions must be in original bottles.

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent boosters.

IMMUNIZATION HISTORY:

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5		Dose 1	Dose 2
DPT/DTaP						Td/DT		
OPV/IPV						MMR		
HIB						TB/PPD		
Hep B								

MEDICAL EXAMINATION: To be filled out by licensed physician, advanced registered nurse practitioner, or a physician's assistant. This form must be returned to us within one month of application. Acceptance on team is pending receipt of this form.

CODE: S Satisfactory N Not Satisfactory O Not Examined

Height _____ Weight _____ B.P. _____ Hgb. Test _____ Urinalysis _____
 Eyes _____ Glasses _____ Extremities _____ Posture (Spine) _____
 Ears _____ Nose _____ Throat _____ Heart _____
 Lungs _____ Abdomen _____ Hernia _____

I have examined the person herein described, and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in a work team to Haiti.

Date of physical: _____

Physician Signature _____ MD Date _____
 Address _____ City _____ State _____ Zip _____
 Telephone(____) _____

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