Personal Health Checklist

This form must be completed by each person who is traveling and a copy should be brought along on the trip with the site-specific Health and Safety Plan (HASP), by the Health and Safety Officer. **This form is not to be submitted to the EWBUSA office.** Consult ISOS (*www.internationalsos.com*), WHO (*http://www.who.int/ith/preface.html)*, CDC (*http://www.cdc.gov/travel/)* websites and your local travel clinic and/or personal physician for travel and health advisories for the area.

Name: _____ Date of Birth: _____ Age:_____

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

Passport #: _____

Phone: (__)_____ E-Mail Address: _____

Emergency Contact: (Name and relationship): _____

Phone: (__)_____ Alternative Phone:_____ E-Mail address: _____

Travel and Evacuation Insurance Information:
The plan must cover volunteer when s/he is out of the country and cover volunteer's evacuation in case of an emergency.

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.*

◊ I **do not take any medication** on a routine basis **OR**

◊ I take the following medications: (*Include birth control and all medications that are taken on an as needed basis as well, such as epinephrine for allergic reactions, asthma inhalers, etc. Add additional pages as needed.*)

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:
Have you had a recent injury, illness or infectious disease? No____ Yes ____ Treatment _____
Do you have diabetes? No_____ Yes _____ Treatment_____
Do you have asthma? No_____ Yes _____ Treatment_____
Have you ever had seizures? No_____ Yes _____ Treatment_____
Do you have any psychiatric conditions that may require treatment? No_____ Yes _____
Any other health issue someone should be aware of in an emergency? _____
What is your blood type? _____

Tuberculosis Screening
Most Recent TB PPD Skin Test: Date_____ Size (mm) _____ Result _____
(PPD test should be done 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: *(Write in the dates you received the following immunizations. Remember to keep a copy at home and travel with your yellow international immunization card.)*

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: _____

Volunteer Signature: _____ DOB: _____

Disclaimer: While EWB-USA is not a health care provider or agency subject to regulation under the Health Insurance Portability and Accountability Act (HIPAA), EWB-USA appreciates that a person's medical history is personal information and will endeavor to preserve the confidentiality of all information provided herein. Only Health and Safety Officers will have access to your personal medical information, and each authorized person understands that such information may be accessed and used by them only as necessary to inform health care providers of your medical needs in time of emergency, or for other authorized, legitimate reasons.

