Glens Falls Medical Mission Foundation

PROJECT GUATEMALA
www.gfmmf.org

MEDICAL APPLICATION

Name (Please Print) _____

Complete and sign this form. Return it with the Volunteer Application, a copy of your passport and a copyof your medical license, if applicable. Please mail to: GFMMF, PO Box 627, Glens Falls, NY 12801-0627.

Required vaccines:

Note: **These immunizations are mandatory for participation**. If you have not had them, do so promptly and inform us of the dates once you have had the vaccines.

Tetanus *(within the last 10 years – preferably only 7-8 years)* Yes ☐ No ☐ If yes, what is the date of your last Tetanus shot: _____ **If no**, **get the vaccine promptly**.

Hepatitis B series Yes ☐ No ☐ *(series of 3 injections – initial and then at 1 month and at 6 months – get at least the first two – you can get the final injection at the next 6-month mark)*
If yes, dates of Hep B series: _____, _____, _____

Hepatitis A series Yes ☐ No ☐ *(initial injection with a booster in 6 months – get at least the initial injection – you can get the booster later at the 6-month mark)*
If yes, dates of Hep A series: _____, _____

Have you ever had any surgery? If so, please state when and what the surgery was for:
_____
_____
_____

Do you have any medical conditions or physical limitations the mission should know about?
_____
_____

Are you allergic to any foods, medications or environmental substances? If so, please list**:**
_____
_____

Any comments or concerns?
_____
_____
_____
_____

Most recent BP _____/_____ Weight _____

Please list your **current active health problems and treatments**. This would include, but not be limited to such conditions as high blood pressure, diabetes, heart disease, bipolar disorder, etc. Include any physically handicapping conditions. *Use the back or attach another page if necessary.*

Disease or disorder:	**Current Treatment:** drug	strength	frequency
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Please list any other medications, supplements, herbals, etc. that are not included above.

_____

_____

_____

_____

In case of emergency, notify:

Name: _____

Address: _____

Telephone: _____ Email: _____

I have provided accurate information on my current health condition.
I understand and accept the possible medical risks of participating in this mission.

_____ _____

Signature Date

_____ _____

Parent's Signature if a Minor Date

CONSENT FOR MEDICAL TREATMENT

I hereby agree to the performance of any emergency medical treatment, anesthetics and/or operations deemed necessary by an attending physician on:

_____

Print name of applicant

I realize this authority is being granted for domestic and non-domestic territory only while volunteering on this medical mission. I understand that I am responsible for providing medical and accident insurance to cover activities while participating in any Glens Falls Medical Mission Foundation program, PROJECT GUATEMALA.

_____ _____

Signature of applicant (or parent/legal guardian, if a minor) Date