

Guatemala 2010

Youth Mission Adventure

Personal Health Record

| | | |
|---|---|----------------------|
| Last Name _____ | First Name _____ | MI _____ |
| Home Address _____ | | |
| Home Phone () _____ | Other Phone (school, cell, etc.) () _____ | |
| Date of Birth (MM/DD/YY) ____/____/____ | Age _____ | Place of Birth _____ |

| | |
|--------------------------------|--|
| Passport Number _____ | Country of Issue _____ |
| Passport Expiration Date _____ | Occupation _____ |
| Social Security No. _____ | Alien Registration No. (if non-US citizen) _____ |

| | |
|--|-----------------|
| In case of emergency, please contact _____ | Relation _____ |
| Phone Numbers () _____ | or () _____ |

Your Doctor _____ Phone () _____

Health Insurance _____ Group No. _____ Policy No. _____

VACCINATIONS AND BOOSTERS

Did you have all DPT/OPV/MMR shots as a child? _____

Last DT and MMR booster within 10 years? _____ Last OPV booster within 6 years? _____

Have you had the Hepatitis B immunization? (3 shots) _____

Have you had the Hepatitis A immunization? (1 or 2 shots) _____

Are you taking or planning to take medication to prevent malaria? _____ What type? _____

Other vaccinations you are planning to get _____

List all important medical diagnoses and any previous surgeries or major illnesses.

List all known allergies to food or medicines, etc.

List all medications to be taken daily or occasionally during this trip.

| Medicine | Dose (mg) | Frequency |
|----------|-----------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

CONSENT TO TRAVEL AND TREAT (if participant is under 18 years of age)

As the parent/guardian of _____, I give my permission for him/her to travel with and under the direction of the leaders and adult sponsors of the Youth Mission Adventure project. I give specific permission for emergency medical and/or surgical treatment for him/her if a medical emergency arises. I have provided the above medical information, and will see that he/she has any necessary medications that may be needed during the trip, and that all vaccinations are up to date. This *permission to treat* is valid from (date) _____ until he/she is returned to my custody.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Notes....

(Please remember to pack sunscreen/hat/insect repellent/long sleeved clothes to protect limbs from sun, insects, etc.)