Medical history and consent form.

DATE:_____

fundación Charles Darwin foundation

SECTION 1 – General Information

Participant

Name _____

Gender F ___ M___

Age _____ Birth ____ / ____ / ____

Occupation

_____

Email _____

Address

_____

_____

City _____

Phone numbers _____

Mobile phone numbers

_____

Mother/Legal guardian

Name _____

Relationship _____

Phone numbers _____

Email _____

Father/Legal guardian

Name _____

Relationship _____

Phone numbers _____

Email _____

Emergency Contact (different than parents/Legal guardian)

Name _____

Relationship _____

Home telephone number _____

Work phone number _____

Mobile phone number _____

Family Doctor

Name _____

Work phone number _____

Mobile phone number _____

Health insurance information

Do you have insurance? Yes _____ No _____

Name of the insurer_____ Policy number _____

SECTION 2 – Past and Current Medical Problems.

A. Conditions and Symptoms (Please answer for each condition)

#	Condition	Yes	No
1	High blood pressure		
2	Heart disease		
3	Heart murmur		
4	Arrhythmia		
5	Family history of heart attacks		
6	Tuberculosis		
7	Recent exposure to active tuberculosis		
8	Positive skin test for tuberculosis		
9	Current hepatitis		
10	History of hepatitis		
11	Epilepsy		
12	Seizures		
13	Blood-clotting problems		

#	Condition	Yes	No
25	Lupus		
26	Freezing of tissues		
27	Circulatory problems		
28	Bed wetting		
29	Head injuries with neurological deterioration		
30	Headaches /Migraine		
31	Stomach ulcers		
32	Intestinal problems, constipation or diarrhea		
33	Heat stroke		
34	Urinary tract infection		
35	Kidney problems		
36	Thyroid Problems		
37	Endocrine problems		

#	Condition	Yes	No
49	Ankle problems		
50	Leg / hip problems		
51	Foot problems		
52	Current pregnancy		
53	Pacemakers, prostheses or other devices		
54	Learning problems		
55	Special diet		
56	Dramatic weight loss		
57	Altitude sickness		

Do you regularly have one of the following symptoms?

58	Pain or pressure in the chest		
59	Heart palpitations		

14	Anemia			**38**	Hearing disability			**60**	Shortness of breath		
15	Chronic cough			**39**	Visual disability			**61**	Heavy sweating		
16	Recurrent lung infections			**40**	Vertigo			**62**	Frequent dizziness		
17	Asthma			**41**	Sleepwalking			**63**	Frequent fainting		
18	Allergic rhinitis			**42**	Broken bones			**64**	Muscle cramps		
19	Diabetes			**43**	Neck problems			**65**	Heat intolerance		
20	Hypoglycemia			**44**	Back problems			**66**	Premenstrual problems		
21	Anorexia			**45**	Elbows, hands, wrists problems			**67**	Intolerance to cold temperatures		
22	Bulimia			**46**	Shoulder Problems			**68**	Do you snore or does someone who sleeps nearby tell you that you snore?		
23	Cancer			**47**	Knee problems			**69**	Other		
24	Skin problems			**48**	Arthritis						

If you have answered "Yes" to any of the above conditions, please explain below. Include information regarding:

*Specific symptoms *Duration of symptoms *Date of last occurrence
*Frequency of symptoms *Treatment for symptoms *Impediments

#	Detailed description

B. Allergies - to medications, food, insects, ...

Allergy	Reaction	Treatment

C. Medications you are currently taking

Medicine	Medical condition	Dosage	Schedule

D. Hospitalization / Emergencies

Date of admission	Reason	Length of stay

E. <u>Food Restrictions or Special Diets, please specify:</u>

_____
_____
_____

F. Swimming Skills (choose one)

____Non-swimmer ____Beginner ____Moderate

____Advanced

G. Do you have a diving certification?

Yes ___ No ___

What type of certification do you have?

_____

What was the date of your last dive? _____

IMPORTANT: *All the aforementioned information must be fully completed, as we need to be aware of those conditions for your benefit. If there is a pre-existing condition that is indicated in the medical record and you are obliged to leave the program for that condition, the cost of the evacuation will be charged to you.*

The information provided above is a complete and accurate statement of physiological and physical factors that may affect my participation in the program. I know that failing to deliver such information can result in serious harm to me and my colleagues. I agree to indemnify and hold harmless the Charles Darwin Research Station if the information provided is not correct.

While volunteering with the CDF, the participant grants permission to provide, at the Foundation's discretion, authorization for any emergency care, anesthesia, surgery, hospitalization or other treatment that may become necessary.

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I, _____, understand that the program involves challenging activities, both physically and emotionally, in a remote and wild area.
My signature at the end of this document indicates my genuine desire to participate in the Volunteer Program. I have read the entire document and completed the form with accurate and truthful information.

_____ _____ _____

Name of the participant **Signature of Participant** **Date**

If the participant is under age:

I (we) give consent to participation in the program to the person mentioned above. I (we) acknowledge and accept the responsibilities and risks of the program and release the Charles Darwin Research Station and its staff from legal liability.

_____ _____ _____

Legal Guardian **Signature of legal Guardian** **Date**