



# Medical Form

Als Freiwilliger wird der Teilnehmer für einen längeren Zeitraum in einer fremden Umgebung wohnen und ggf. in einem sozialen oder ökologischen Projekt arbeiten. Deshalb ist es wichtig, dass wir über physische oder mentale gesundheitliche Probleme Bescheid wissen. Dies ist wichtig, um über die endgültige Teilnahme des Bewerbers zu entscheiden.

Bitte vom Freiwilligen oder einem Arzt auszufüllen. Bitte vom Arzt unterschreiben lassen. Anschließend einscannen und per Email an uns senden. Das Original bitte aufheben, für den Fall der Auswahl benötigen wir das Original.

Last Name of applicant: \_\_\_\_\_ First Name: \_\_\_\_\_

Date and Place of Birth (dd/mm/yyyy): \_\_\_\_\_

Do you have allergies? Yes  No  **If yes, list allergies and describe your symptoms and treatment:** \_\_\_\_\_

Do you take regular medications or drugs? Yes  No  **If yes, list medications and conditions being treated:** \_\_\_\_\_

Do you have any special dietary requirements? Yes  No  **If yes, what are they?** \_\_\_\_\_

In the last 12 months, have you been hospitalised or received treatment for any medical condition? Yes  No

**If yes, please describe:** \_\_\_\_\_

Have you ever needed treatment, counselling or hospitalisation for a psychological or psychiatric condition? Yes  No

**If yes, please describe:** \_\_\_\_\_

Do you have a disability? Yes  No

**If yes, please describe:** \_\_\_\_\_

Are you presently recovering from an injury? Yes  No

**If yes, please describe:** \_\_\_\_\_

Tick the appropriate box if you presently suffer from or have ever had:

- |                                   |                                       |                                      |
|-----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> anorexia | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> epilepsy    |
| <input type="checkbox"/> mumps    | <input type="checkbox"/> hepatitis A  | <input type="checkbox"/> hepatitis B |
| <input type="checkbox"/> malaria  | <input type="checkbox"/> polio        | <input type="checkbox"/> depression  |
| <input type="checkbox"/> bulimia  | <input type="checkbox"/> diabetes     | <input type="checkbox"/> asthma      |

If you have ticked any of the above, give details including dates as applicable: \_\_\_\_\_

Please indicate whether you have been immunised against the following:

- |   |                                     |                                       |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> hepatitis A    | <input type="checkbox"/> tetanus    | <input type="checkbox"/> polio        |
| <input type="checkbox"/> hepatitis B    | <input type="checkbox"/> typhoid    | <input type="checkbox"/> measles      |
| <input type="checkbox"/> mumps          | <input type="checkbox"/> diphtheria | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> German measles |                                     |                                       |

Please describe your overall health condition:  Excellent  Very Good  Good  Fair  Poor

Please describe your strength and endurance:  Excellent  Very Good  Good  Fair  Poor

## PERSONAL DOCTOR CONTACT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature and Stamp of Doctor

Date: