RALEIGH EXPEDITION MEDICAL FORM

Please complete this form yourself before to taking it to your GP (family doctor)

Programme Country: Dates (from/to):

First Name: Family name:

Date of Birth: Age: Raleigh ID:

PLEASE RETURN TO THE RALEIGH MEDICAL TEAM (fax 02075048094 or email: raleighmedicscreening@raleighinternational.org)

PERSONAL HEALTH

Please be as honest as possible with these questions so that we have the information we need to ensure your safety on programme. A member of the Raleigh Medical Team will be in contact with you if any follow up is required.Please do not book your flights until you have comfirmed you have been medically cleared. Failure to diclose information may invalidate your insurance and leave you liable for any costs incurred.

DO YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM:

1. Heart Problems (e.g. arrhythmia, high or low blood pressure, congential or other disease)	**Yes** ☐ **No** ☐	**8. Breaks Fractures, dislocations**	**Yes** ☐ **No** ☐
2. Blood or bleeding disorders	**Yes** ☐ **No** ☐	**9. Any learning needs or developmental disorders (e.g. Asperger's, autism, ADHD, dyspraxia)**	**Yes** ☐ **No** ☐
3. Surgery / operation	**Yes** ☐ **No** ☐	**10. Any physical or other disability**	**Yes** ☐ **No** ☐
4. Gastric or physical eating problems	**Yes** ☐ **No** ☐	**11. An infectious tropical disease**	**Yes** ☐ **No** ☐
5. Skin Conditions	**Yes** ☐ **No** ☐	**12. Drug or alcohol abuse**	**Yes** ☐ **No** ☐
6. Recurrent infections (e.g. urinary, thrush, respiritory, ear, eye)	**Yes** ☐ **No** ☐	**13. Fainting/ loss of consciousness**	**Yes** ☐ **No** ☐
7. Soft tissue, nerve or joint injury (e.g. tendon, ligament, cartilage)	**Yes** ☐ **No** ☐	**14. Head Injury/ migraine**	**Yes** ☐ **No** ☐
		15. Any other health related problem	**Yes** ☐ **No** ☐

If yes to any of the above, please give full details:

(include dates, nature of illness or injury, treatment, recurrances, ongoing medical advice and any support needs)

16. Epilepsy, fits or seizures **Yes** ☐ **No** ☐ If yes, please request additional 'Epilepsy, fits and seizures screening form'

17. Diabetes **Yes** ☐ **No** ☐ If yes, please request additional 'Diabetes Screening Form'

18. Allergies **Yes** ☐ **No** ☐ If yes, please list your allergies below;

Allergen *e.g. 'peanuts'* Exposure *e.g. 'touching'* Reaction *e.g 'anaphylaxis'* Medication *e.g. 'epipen'*

Allergen _____ Exposure _____ Reaction _____ Medication _____

Allergen _____ Exposure _____ Reaction _____ Medication _____

Allergen _____ Exposure _____ Reaction _____ Medication _____

Please provide any information about allergies or intolerances you may have here:

PERSONAL HEALTH CONTINUED

Name:

19. Mental Heath

DO YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM:

19a Panic/Anxiety Attacks Yes ☐ No ☐

If Yes: What happens when you have one? _____

How often do you have them? _____

When was your last attack? _____

19b Anxiety Yes ☐ No ☐

If Yes: How long have you suffered from anxiety? _____

Have sought professional help for this? If so, when and who? _____

Do you currently take any medications for anxiety? If so, what? (please include dosage and frequency)

_____

Have you had, or are you currently undergoing any therapy for anxiety (e.g. CBT, counselling). If so, what? (please include dates)

_____

19c Depression Yes ☐ No ☐

If Yes: How long have you suffered from depression? _____

Have you sought proffessional help for this? If yes when and who? _____

Do you currently take any medications for depression? If so, what? _____

Have you had, or are you currently undergoing any therapy for depression (e.g. CBT, counselling). If so, what? (please include dates)

_____

19d Eating Disorder Yes ☐ No ☐

If Yes: If yes please detail (include dates, nature of illness or injury, treatment, ongoing medical advice and any support needs)

_____

_____

What is your current; Weight: __ Height: __

19e Any other Mental Health Problem Yes ☐ No ☐

If Yes, please provide details including dates of illness, treatment, ongoing medical advice and support needs

_____

_____

19f Self harm, overdose, suicidal thoughts or attempts? Yes ☐ No ☐

If Yes, please provide details including dates, treatment, ongoing medical advice and support needs.

_____

_____

Please be as honest as possible with these questions, so that we can have the information we need to ensure your safety on programme. A member of the Raleigh Medical Team will be in contact with you if any follow up is required.

PERSONAL HEALTH CONTINUED

Name:

20. Asthma **Yes** ☐ **No** ☐ If yes please answer the questions below;

When were you diagnosed with asthma? Date: _____

What type of inhalers do you use (if any)? Include dose and frequency _____

Do you have any specific triggers that make your asthma worse? Details; _____

When was your last asthma review? Date: _____

Have you ever had an asthma attack? Yes ☐ No ☐ If yes, how frequently do you have attacks? _____

When was your last attack? _____

Have you ever been hospitalised because of asthma? Yes ☐ No ☐ If yes, when? Date: _____ Details: _____

Have you ever been in Intensive care with your asthma? Yes ☐ No ☐ If yes, when? Date; _____

Details: _____

Any additional information about your asthma; _____

21. Please list any regular medications/remedies you are taking (and any additonal you will be taking during expedition). Please include doseage, how often and how long you have been taking this medication for

22. Have you visited a health professional (e.g. nurse, doctor, therapist) or attended hospital in the last 5 years? (If yes, please give full details of dates, nature of illness/injury and treatment received)

IF ANYTHING REGUARDING YOUR HEALTH CHANGES AFTER RETURNING THIS FORM, YOU MUST INFORM THE MEDICAL TEAM. FAILURE TO DO SO MAY AFFFECT YOUR PLACE ON EXPEDITION AND MAY INVALIDATE YOUR INSURANCE.

DECLARATION

VOLUNTEER

To the best of my knowledge this is a true and accurate account of my medical history and current condition. If my medical condition changes after submitting the form I will inform the Raleigh Medical Team.

In the event of accident, illness or if additional information is required by a member of the Raleigh Medical Team, I give my permission for Raleigh International to initiate treatment, and contact my GP, other relavent healthcare professional, key worker and/or next of kin.

The Raleigh International Medical Team respects the confidentiality of volunteers. However for safety reasons it is sometimes necessary to share medical information with other Raleigh staff. I consent to the medical information contained herewith, or any medical issues which occur on programme, to be shared with Raleigh Volunteer Medics and UK/ in-country management teams where deemed operationally necessary.

Name: Signature: Date:

Name of Parent (if under 18): Signature of Parent (if under 18):

Please do not book flights untill you have checked you have been medical cleared by the Raleigh Medical Team.

NOTE: YOU MAY PUT YOURSELF AT SIGNIFICANT RISK (AND YOUR INSURANCE INVALIDATED) IF ANY INFORMATION REGUARDING YOUR PAST OR CURRENT HEALTH IS OVERLOOKED OR NOT INCLUDED IN THIS FORM

GENERAL PRACTIONER (GP)

Please consider the information below and the guidance from our corresponding doctor's letter. If there are any matters which you feel the Medical Team should be aware, please state on the medical form or supply on a separate note. If you have any queries, or concerns around this volunteer's suitability to participate on expedition, please feel free to contact the Raleigh Medical Team on 02071831291.

This person will be participating in a five, seven or ten week Raleigh International overseas programme. Remote project sites are often several hours from a hospital.

They will be subject to:

basic living and sleeping conditions in remote environment

considerable mental stress as part of a small team

challenging climates

a three week trek carrying a full rucksac, and six weeks of strenuous infrastructure work

I have read the above paragraph and to the best of my knowledge, I believe this person is fit to travel and participate on the programme. This account is a true and accurate description of the medical history and current medical condition of the named person.

Doctor's Name (in capitals):

Doctor's Signature:

GMC number: Date

Surgery Address

Surgery Stamp