RALEIGH EXPEDITION PROGRAMME MEDICAL FORM

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

Programme Country: Dates (from/to):

First Name: Last name:

Date of Birth: Age:

PLEASE RETURN TO YOUR VOLUNTEER COORDINATOR VIA EMAIL: nepalraleigh@raleighinternaitonal.org or raleighcostarica@raleighinternational.org or raleightanzania@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. We advise you 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. What is your current; Weight: ______KG Height: __________CM

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

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)

Question	Yes	No	
18. Epilepsy, fits or seizures	☐	☐	If yes, please request additional 'Epilepsy, fits and seizures screening form'
19. Diabetes	☐	☐	If yes, please request additional 'Diabetes Screening Form'
20. Allergies	☐	☐	If yes, please list your allergies below;

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

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

PERSONAL HEALTH CONTINUED

Name:

21. Mental Heath

DO YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM:

21a Panic/Anxiety Attacks Yes ☐ No ☐

If Yes: What happens when you have one?

How often do you have them?

When was your last attack?

21b 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)

21c 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)

21d 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)

21e Any other Mental Health Problem Yes ☐ No ☐

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

21f 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:

22. 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;

23. 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

24. 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 PROGRAMME 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.

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, our insurance company and our medical assistance company. 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/ Raleighs insurancers/Raleighs medical assistance organistion where deemed operationally necessary in the interest of safety.

Name: Signature: Date:

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

Please note that we advise you wait until untill you have been medical cleared by the Raleigh Medical Team before booking your flights.

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)

This person will be participating in a 4-16 week Raleigh International Expedition programme. Remote project sites are often several hours from a hospital. They will be subject to: basic living/sleeping conditions in remote environment, considerable mental stress as part of a small team, challenging climates, walking carrying a full rucksac, and possibly strenuous infrastructure work.

Please consider this information and the guidance from our corresponding doctor's letter. We do NOT ask GP to certify individuals “fit to travel” as the final medical clearance decisions lies with the Raleigh Medical Team. However, if there are any matters which you feel the Medical Team should be aware, or any recommendations pertaining to this individual’s specific health condition whilst undertaking a placement of this kind, please state them here (or on separate letter if necessary):

I have read the above paragraph and to the best of my knowledge, I believe 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