Medical Form

Als Freiwilliger oder Demi Pair wird der Teilnehmer für einen längeren Zeitraum in einer fremden Familie 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 / Demi Pair oder einem Arzt auszufüllen. Bitte vom Arzt unterschreiben lassen.

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:

☐ anorexia ☐ tuberculosis ☐ epilepsy
☐ mumps ☐ hepatitis A ☐ hepatitis B
☐ malaria ☐ polio ☐ diabetes
☐ depression ☐ bulimia ☐ asthma

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

____

____

Pleas indicate whether you have been immunised against the following:

☐ hepatitis A ☐ tetanus ☐ polio
☐ hepatitis B ☐ typhoid ☐ mumps
☐ diphtheria ☐ yellow fever ☐ measles
☐ 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