VOLUNTEER HEALTH DECLARATION

Name and surnames -

Date of birth -

Please answer whether you suffer from or have ever suffered from any of the following conditions. If "Yes", please give details of the severity, treatment, and history of the condition the "Medical details" section of the next page.

	Yes	No
Recurrent respiratory or throat problems. Laryngitis, asthma, bronchitis, tuberculosis, other.	☐	☐
Visual impairment. Short- or near-sightedness, stigmatism, daltonism, other.	☐	☐
Other conditions affecting the eyes. Conjunctivitis, cataracts, other.	☐	☐
Joint or muscle pains or diseases. Arthritis, rheumatism, gout, lumbago, neck pains, other.	☐	☐
Blood disorders. Anaemia, von Willebrand's, sensitivity to aspirin, other.	☐	☐
Heart conditions. Palpitations, hypo- or hypertension, heart attack or failure, vascular disease, other.	☐	☐
Endocrine or hormonal disorders. Diabetes, hypo- or hyperthyroidism, other.	☐	☐
Allergies. Hay fever, insect allergies, food allergies, other.	☐	☐
Skin conditions. Eczema, psoriasis, cellulitis, urticaria, solar hypersensitivity, other.	☐	☐
Headaches / consciousness, etc. Migraines, epilepsy, blackouts, strokes, other.	☐	☐
Psychological, behavioural, or emotional conditions. Phobias, vertigo, depression, anxiety, other.	☐	☐
Conditions requiring surgical intervention? Appendicitis, tonsillitis, kidney failure, protheses, other.	☐	☐
Parasitic infections. Malaria, leishmaniasis, intestinal worms, schistosomiasis, other.	☐	☐

General practitioner contact details:

Name:

Address:

Email address:

Telephone number:

Next of kin / in case of emergency:

Name:

Address:

Email address:

Telephone number:

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Please answer the following questions about your lifestyle at home and give any necessary details in the adjacent column.

	Yes	No
Do you smoke?	☐	☐
Do have any special dietary requirements?	☐	☐
Are you currently on any medication?	☐	☐
Do you travel frequently?	☐	☐

Any other health or fitness information you feel is relevant to mention:

Medical details

If you answered 'Yes' to any of the above, please give details here, including the severity, any treatment you may have had or be taking, history of the condition and how you manage it if ongoing or chronic. Use as much space as you need, your health is important and we want you to be able to make the most out of your time with us!

I ……………………………………………………, date of birth ……./……./………., passport number …………………… and ……………………. nationality, have filled out this form to the best of my knowledge and have consulted my General Practitioner / a doctor about living in a remote region in Ecuador and attach an up-to-date vaccination history.