CONFIDENTIAL – HEALTH FORM

(If the Applicant is under 21 years of age, parent or legal guardian is to assist in obtaining information)

PLEASE WRITE CLEARLY.

Name (as in Passport): _____ Date of Birth: _____

Passport No.: _____ Expiry Date: _____

Email: _____ Contact No.: _____

Mission Location: _____ Dates of Trip: _____

Health (tick one) [ ] Excellent [ ] Good [ ] Fair [ ] Poor
Blood Type : _____

Blood Pressure (tick one) [ ] Normal [ ] Low [ ] High

History (Example: Medical / Surgery / Accident / Mental / Serious illness / Family)

_____

_____

Are you on any form of medication / doctor's care? [ ] Yes [ ] No

If **YES**, please give details: _____

_____

_____

Do you suffer from or have been treated for any of the following? (*Please tick and give details below)*

[ ] Anemia [ ] Food/Skin allergy [ ] Disease of Brain or Nervous System
[ ] Chest Pain [ ] Heart Disease [ ] Disease of Blood or Metabolism
[ ] Diabetes [ ] Hepatitis [ ] Disease of Kidney/Genito Urinary System
[ ] Drug Allergy [ ] Migraine [ ] Disease of Muscles or Bones
[ ] Epilepsy [ ] Stroke [ ] Respiratory Disorder / Asthma
[ ] Fainting Spells [ ] Emotional / Depression.
[ ] Others : _____ * For Females only : Are you pregnant? **YES / NO**

Details:

_____

_____

In case of Emergency, who should we contact? (if travelling together with your emergency contact, please provide another contact number)

Full Name: _____ Relationship (eg. Father/Mother) _____

Tel: (Day) _____(Night) _____(H/p)_____