Name (First & Last): ____________________________

Confidential Health Form I (CHF-I)

(Please write legibly in ink or type into pdf form)

Note: *Providing false, misleading and/or incomplete information may seriously endanger the health of a participant and is grounds for his/her dismissal from the AMIGOS program. Participant files, including medical forms, are considered confidential and information is released by the International Office on a need-to-know basis only. Disclosure of a medical condition does not automatically disqualify an applicant from admission to the program, but may result in further screening to determine appropriateness for AMIGOS service.*

Participant Information

Gender: ☐ Male ☐ Female	**Phone Number: (☐ home or ☐cell)**
Date of Birth: / /	
Height: ft. in.	**Health Insurance Carrier:**
Weight: lbs.	**Health Insurance Policy/ID #:**
Email Address:	**Health Insurance Carrier phone #:**

Physical Health & History

(1) Do you have any (or have a history) of the following conditions? (*check the appropriate boxes*):

	YES	**NO**
Asthma requiring daily medication use	☐	☐
Serious food/insect allergy requiring the availability of EpiPen	☐	☐
Seizure disorder	☐	☐
Diabetes	☐	☐
Any orthopedic/neurologic condition that impairs your mobility	☐	☐
Any congenital medical conditions (e.g. congenital heart disease)	☐	☐
Hypertension	☐	☐
Altitude sickness	☐	☐
Any other health condition that may need to be taken into consideration	☐	☐

(2) If you answered "yes" to any of the above, please explain your condition(s) *(e.g. list foods that you are allergic to)* <u>*AND*</u> provide the name and dosage of any medications that you take to manage/treat each listed condition(s) below.

Explanation: ____

Medication Name	**Dosage** (e.g. 5mg)	**Frequency** (e.g. 2x/day)	**Side Effects** (include known & potential)	**Reason for Taking**

Name (First & Last): ____________________________

(3) Please provide the full name and contact information (office phone number & location) for the treating clinicians for the aforementioned conditions. (*The health screener may not be in the same time zone*).

Name of clinician: ______________________________

Office phone number: ___________________________

Location: ______________________________________

Mental Health & History

(1) Have you ever sought professional help for a psychological or behavioral problem? (Including ADHD or an Eating Disorder)

☐ Yes ☐ No

If yes, please explain here:

____

(2) Currently and/or during the past two years have you…? (*check & complete the appropriate boxes*):

	YES	NO	DATES	REASON/EXPLANATION
Received outpatient mental health services (e.g. therapy or counseling sessions)	☐	☐		
Received inpatient psychiatric services (e.g. hospitalization for psychiatric treatment)	☐	☐		
Received chemical dependency services	☐	☐		
Received treatment in an Eating Disorder Program	☐	☐		

(3) Are you currently, or have you within the past two years, taken prescribed medication for a psychological or behavioral problem?

☐ Yes ☐ No

If yes, please document all medication name information in the below table.

Medication Name	**Dosage** (e.g. 5mg)	**Frequency** (e.g. 2x/day)	**Side Effects** (include known & potential)	**Reason for Taking**

Name (First & Last): ____________________________

(4) Please provide the full name and contact information (office phone number & location) for the treating clinicians for the aforementioned conditions. (*The health screener may not be in the same time zone*).

Name of clinician: ______________________________

Office phone number: ___________________________

Location: ______________________________________

I hereby certify that the information provided in Confidential Health Form I is complete and accurate. I understand that submission of inaccurate and/or incomplete information about my medical and/or emotional health history may result in my dismissal from the AMIGOS program. I agree that if any substantial change should occur in my medical and/or emotional health prior to my departure for training and Latin America Service Program locations, I will also inform AMIGOS in writing immediately. I further agree that I will sign a release form with my treating clinician(s) to allow the exchange of information with authorized AMIGOS health screeners.

Note: *If the Participant is under 18 years of age, at least one custodial parent or legal guardian must sign this release and provide contact information.*

Participant's Signature: ____ Date: _______________

Signature of Parent (or Legal Guardian): __________________________________ Date: _______________

Name & all contact information parent or legal guardian (if under 18 years old) who would like to be contacted for health screening:

Name of parent or legal guardian: _________________________________

Preferred contact phone number: ______________________________

Email address: ____