LEGACY INSTITUTE
P.O. Box 575, Monrovia, CA 91016

VOLUNTEER APPLICATION
HEALTH SUPPLEMENT

This Health Supplement to the Volunteer Application must be completed and signed by each applicant. **PLEASE PRINT IN INK.**

HEALTH INFORMATION

Name: _____
First Middle Last

Sex: _____ Male _____ Female Birth Date: _____/_____/_____
Day Month Year

Address: _____
Street Address City State/Province Zip/Postal

Social Security Number of Applicant: _____ - _____ - _____ Telephone: (_____)_____

Parent/Guardian or Emergency Contact: _____ Relationship: _____

(_____)_____ (_____)_____ Email: _____
Home Telephone Work Telephone

Parent/Guardian or Emergency Contact: _____ Relationship: _____

(_____)_____ (_____)_____ Email: _____
Home Telephone Work Telephone

INSURANCE INFORMATION

A certificate of health insurance is required. Legacy Institute does not provide volunteers with health, life, and accident insurance. However, all volunteers are required to obtain health insurance for the period of service on a Legacy Institute project. IMPORTANT: Health insurance must provide coverage in the country in which the applicant is volunteering to serve. Please provide the following health insurance information.

Health Insurance Company: _____ Policy No. _____

Address: _____
Street Address City State/Province Zip/Postal

Telephone: (_____)_____ Social Security Number of Policy Holder: _____ - _____ - _____OR

Insurance ID Number: _____

MEDICAL INFORMATION

A disability will not prevent the consideration of an applicant. However, applicant medical information is important, because some Legacy Institute projects are physically demanding, geographically isolated, and may be unsuitable for an applicant with health considerations, or who might need medications that are not readily available at a project location. NOTE: Applicant may be asked to have a physical examination.

DOES APPLICANT HAVE:

1. Any health problem or disabilities that may prevent participation in physically demanding activities? ____Yes _____ No

If yes, please explain (attach note if necessary):

2. Any severe allergies (including food / drug / environmental sensitivities)? _____Yes _____ No

If yes, please explain (attach note if necessary):

3. Any allergy to MSG (Mono Sodium Glutamate)? _____Yes _____ No

If yes, please explain (attach note if necessary):

4. Are you routinely taking any medications (including non-prescription or over-the-counter drugs)? _____Yes _____ No

If yes, please list all medications below. IMPORTANT: International Customs Laws require that prescription medications must be transported in the original packages that clearly indicate: the doctor, dosage, and frequency of administration.

Medication	Dosage	Frequency	Purpose of Medication

5. Please complete the following health history – explain any "yes" answers below. Has the applicant ever had or does the applicant have:

1. A recent injury, illness or infectious disease? . . . . . ☐Yes ☐No
2. A chronic or recurring illness? . . . . ☐Yes ☐No
3. Frequent headaches? . . . . . ☐Yes ☐No
4. Severe menstrual pain? . . . . . ☐Yes ☐No
5. Any eyesight impairment? . . . . . ☐Yes ☐No ☐Yes ☐No
6. Any ear or hearing problems? . . . . ☐Yes ☐No
7. Sinus infections? . . . . . ☐Yes ☐No
8. A speech impairment? . . . . . ☐Yes ☐No
9. Frequent throat infections? . . . . . ☐Yes ☐No
10. Chronic skin problems? . . . . . ☐Yes ☐No
11. Dizziness due to exercise? . . . . . ☐Yes ☐No
12. Seizures? . . . . . ☐Yes ☐No
13. Arthritis? . . . . . ☐Yes ☐No
14. Recurring back pain? . . . . . ☐Yes ☐No
15. Hernia? . . . . . ☐Yes ☐No
16. Asthma? . . . . . ☐Yes ☐No
17. Abnormal blood pressure, chest pain, or heart murmur? . . . . . ☐Yes ☐No
18. Heart disease? . . . . . ☐Yes ☐No
19. Rheumatic fever . . . . . ☐Yes ☐No
20. Diabetes? . . . . . ☐Yes ☐No
21. Reoccurring pneumonia? . . . . . ☐Yes ☐No
22. Tuberculosis? . . . . . ☐Yes ☐No
23. Disorders of the Nervous System?. ☐Yes ☐No
24. Kidney disease? . . . . . ☐Yes ☐No
25. Professional treatment for emotional or mental health? . . . . . ☐Yes ☐No
26. Any eating disorders? . . . . . ☐Yes ☐No
27. Special dietary requirements?. ☐Yes ☐No
28. Intestinal disorders? . . . . . ☐Yes ☐No
29. Chicken Pox? . . . . . ☐Yes ☐No
30. Measles / German measles? . . . ☐Yes ☐No
31. Mumps? . . . . . ☐Yes ☐No

Please note the question number and explain all answers marked Yes (attach note if necessary):

_____

_____

_____

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6. Immunizations – fill in the dates for any immunizations the applicant has had:

IMMUNIZATIONS	Date Last Received	IMMUNIZATIONS	Date Last Received
CHICKEN POX		RABIES	
DIPHTHERIA		RUBELLA	
DPT		SMALLPOX	
HEPATITIS A OR IMMUNE GLOBULIN/IG		TETANUS	
HEPATITIS B		TENANUS-DIPHTHERIA/TD	
MEASLES		TYPHOID	
POLIO		OTHER:	

IMPORTANT: A record of immunizations is for informational purposes. Immunizations **are not** required by Legacy Institute for volunteers. However, some countries do require visitors to be immunized for prevention of specific diseases. Therefore, the applicant is responsible for obtaining all immunizations legally required by countries hosting Legacy projects. (NOTE: Thailand requires NO immunizations at this time).

APPLICANT: I certify that to the best of my knowledge that the information above is correct, and complete, and accurately reflects my medical history and current medical condition.

Signature of applicant: _____ Date: _____