Dalit Solidarity

Volunteer Medical Information and Treatment Authorization

Name _____ Birth date _____

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____

Day phone _____ Cell phone _____

Evening phone _____ Email _____

Health Information (check all applicable items and explain below)

Respiratory system
___ Frequent sore throat
___ Persistent cough
___ Asthma
___ Shortness of breath

Cardiovascular system
___ High blood pressure (treated? untreated?)
___ Irregular heartbeat
___ Other (explain below)

Neurological system
___ Fainting spells
___ Seizures
___ Balance problems
___ Chronic dizziness

Musculoskeletal system
___ Frequent muscle spasms
___ Chronic joint dislocations
___ Chronic back problems
___ Other joint difficulties

Gastrointestinal system
___ Diabetes (explain control method)
___ Other (explain below)

Psychological
___ Depression (treated? untreated?)
___ Other (explain below)

Explain any checked items or other facts that caregivers need to know if you are unable to answer questions: _____
_____
_____
_____

Current medications including dosage _____
_____
_____
_____

Are there any types of work/labor that you are unable to do because of physical limitations? ____
_____
_____

Date of last tetanus shot? _____ (must be within past 10 years)

Have you had any systemic allergic reaction to bee stings, food or medicine?
Yes ___ No ___ If yes, what caused the reaction? _____
What was the treatment? _____
(If you have sever allergies, please bring your own EpiPen or Bee Sting kit)

Dalit Solidarity works primarily in Tamil Nadu, India. Emergency treatment will be provided through available doctors, clinics and hospitals in India. Please remember that caution, careful planning and prevention on your part will greatly reduce the need for emergency medical treatment.

Health Insurer Information

Insurance company _____ Member number _____
Doctor's name _____ Doctor's phone _____

Contact your insurance company in advance to learn about your out-of-country coverage and procedures to pay for care.

Authorization and Consent

I hereby authorize the leader(s) of the group that I am participating with or any representative of staff of Dalit Solidarity to consent to the following medical or dental treatment on my behalf:

- Any X-ray examination, medical or surgical diagnosis, treatment and hospital care to be performed by a licensed physician, surgeon, medical clinic or hospital in India or any country to which we travel as a part of this group.
- Any X-ray examination, anesthetic, dental or surgical diagnosis, treatment and hospital care to be performed by a licensed dentist, medical clinic or hospital in India or any country to which we travel as a part of this group.

I also authorize the leader(s) of the group that I am participating with or any representative, agent or staff of Dalit Solidarity to have access to my medical records and to disclose the contents to others.

I understand that, as a volunteer, or a parent or guardian, I will be responsible for the cost of any service or treatment.

_____ _____ _____
Signature Print Name Date

If the volunteer is a minor, the authorization and consent must be given by a parent or legal guardian

_____ _____ _____
Signature Print Name Date