Volunteer Health Statement

NUESTROS PEQUEÑOS HERMANOS INTERNATIONAL

CONFIDENTIAL

Volunteer name: **Date of Birth:**

Country where volunteer will serve:

Insurance (if applicable) Name and policy number:

The applicant listed above has applied for a volunteer position in one of the nine homes of **Nuestros Pequeños Hermanos**, a global child welfare nonprofit that serves children in Mexico, Honduras, Haiti, Nicaragua, Guatemala, El Salvador, Dominican Republic, Peru and Bolivia. Volunteers live and work in difficult conditions and will be exposed to tropical illnesses and other vector-borne diseases.

Good health is of utmost importance for the volunteers. Pre-existing conditions do not disqualify an applicant from service, but it can be difficult to get the same type of care he or she may have in his or her country of origin. The applicant will have access to basic primary healthcare services provided by NPH. Extraordinary care can be sought outside of NPH, but the applicant will have to assume all costs and burden of the services.

Additional documentation will be required for applicants with pre-existing conditions, including mental health conditions.

Applicants who take permanent or chronic medicine must bring either a year's supply or assume all costs of purchasing the medicine in the country of service.

The below health statement must be filled out by a certified physician. Health statements completed by relatives of applicants will not be accepted.

The NPH International Volunteer Program reserves the right to deny an applicant based on health conditions that put the applicant at risk.

To be filled out by a physician:

How long have you known the applicant?

Has the applicant ever been diagnosed with, or does the applicant currently experience any of the following maladies:

	YES	NO
Frequent or severe headaches	☐	☐
Dizziness or fainting spells	☐	☐
Ear, nose or throat infections	☐	☐
Chronic or frequent colds or respiratory infections	☐	☐
Asthma	☐	☐
If yes, please note the type of medication required and frequency of attacks:		
High or low blood pressure	☐	☐
If yes, please note whether patient is taking any medicine, and whether control is achieved:		
Frequent digestive symptoms: stomach or bowel	☐	☐
If yes, please note whether patient is taking any medicine, and whether control is achieved:		
Kidney infections, kidney stones or UTIs	☐	☐
Issues with the eyes, ears, nose, throat or jaw, or dental that require special care	☐	☐
Liver, pancreas, gall bladder	☐	☐
Diabetes- type I or II or other endocrine condition	☐	☐
Depression, anxiety, or excessive worry	☐	☐
If yes, please note whether patient is taking any medicine, and whether control is achieved:		
Any diagnosis of psychiatric illness	☐	☐
If yes, please note whether patient is taking any medicine, and whether control is achieved:		
Blood and blood vessels disorder such as bleeding problems, anemia, hemophilia, etc.	☐	☐
Heart, cardiac or cardiovascular problems	☐	☐
Any disease potentially affecting the immune system	☐	☐
Seizures or other neurological disorders	☐	☐
Allergies (to medication, drugs, vaccines or vaccine components, food like eggs, yeast, insect bites)	☐	☐

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A serious reaction such as hives, rash, wheezing, difficulty breathing	☐	☐
If yes, please note whether patient is taking any medicine, and whether control is achieved:		
History of eating disorder(s)	☐	☐
If yes, was there treatment? When?		
History of drug or alcohol abuse/addiction	☐	☐
If yes, was there treatment? When?		

Please comment on any question answered “yes”:

Is there any medical condition not listed we should be aware of?

Is there any mental health disorder not listed we should be aware of?

Does the applicant take any medication or treatment on a chronic basis for prevention or control of any medical or psychiatric condition? Please provide the generic name of the medication (not manufacturer name).

If the applicant needs a one-year supply of medication, will he/she be able to obtain it prior to his/her departure?

Any condition that will require special accommodation for the applicant?

OTHER COMMENTS OR CONCERNS:

NPH INTERNATIONAL

VACCINATION HISTORY
Please provide the dates of these vaccines and the last booster.

VACCINES REQUIRED BY NPH:

Tetanus/Diptheria/Pertussis					
Hepatitis A					
Hepatitis B					
MMR or SRP					
Yellow Fever *(required only for applicants traveling from or to South America or Panama)*					

Please note if any of the above vaccines are not up to date:

OPTIONAL VACCINES (NOT REQUIRED BY NPH):

Typhoid

Rabies

PPD Test
Has the applicant been working in hospitals?

Has the applicant been in contact with TB patients?

Has a member of the applicant's family been diagnosed with TB?

If the answer is "yes" to any of the above questions, the applicant must receive a PPD Test. If the answer is "no" to ALL of the above questions, the applicant does not need a PPD Test.

Date of PPD test: Result: Please specify in mm
Other TB blood test (name and result)

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If positive:

Date of Chest X-ray:
Result of Chest X-ray:
Dates of treatment:

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The applicant will submit this Health Statement to the Volunteer Coordinator from their sending office, or the International Volunteer Coordinator for applicants from countries without NPH offices. If necessary, the Health Statement will be forwarded to NPHI Medical Services for further consultation. The Health Statement will be shared with the volunteer coordinator of the home of service, as well as the physician of the on-site NPH clinic.

Please refer to the WHO and the CDC websites for travel and health recommendations:
www.cdc.gov/travel
www.who.int

COMMENTS:

** By signing this Health Statement you are verifying that to the extent of your knowledge the applicant is healthy enough to live in a developing country with limited access to healthcare services for a minimum of a year**

Physician's Signature and Stamp:
Physician's Printed name:
Address:
Date:

Failure to disclose a physical or mental health issue to NPH will be grounds for denial of application and/or immediate dismissal.

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