



Our Lady of Lourdes Hospitality
North American Volunteers, LTD.

Health INFORMATION

Please print clearly, sign and mail to: Our Lady of Lourdes Hospitality North American Volunteers, 107 Michaels Ave Syracuse, NY 13208

Last Name (as it appears or will appear on passport):	First Name:	Middle Initial:	Date:
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Home Phone:()	Cell:()	Email:
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<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	Age:	Birth: / / Month Day Year
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*Special diet: none diabetic low sodium gluten-free vegetarian other: _____
 Specialized meals are not available to volunteers; choices must be made from Sanctuary cafeterias daily menu offerings.

Allergies Please list all known allergens:	Please list reaction at exposure: hives, rash, etc.:
Food: _____	_____
Drugs: _____	_____
Other: _____ (latex, animals, plants, pollens, insect stings)	Do you carry an EPI Pen with you? <input type="checkbox"/> Yes <input type="checkbox"/> No

Mobility (ALL manual and electric wheelchairs must be pre-approved by Air France):

<input type="checkbox"/> fully able to walk	<input type="checkbox"/> use a manual wheelchair	<input type="checkbox"/> fully able to sit and stand
<input type="checkbox"/> able to walk short distance	<input type="checkbox"/> provide a wheelchair for me	<input type="checkbox"/> sit/stand with limits/assistance
<input type="checkbox"/> able to go up/down stairs	<input type="checkbox"/> use of stairs with assistance	<input type="checkbox"/> fully able to bend and lift
<input type="checkbox"/> unable to walk	<input type="checkbox"/> use a cane or walker	<input type="checkbox"/> bending and/or lifting restrictions
		<input type="checkbox"/> unable to bend

wheelchair model:	weight:	folded measurement: <small>length x width x height</small>
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Durable Medical Equipment Use/Supplies (please list all equipment or supplies you will travel with):

<input type="checkbox"/> none	<input type="checkbox"/> Bi-Pap machine	<input type="checkbox"/> diabetes supplies
<input type="checkbox"/> feeding pump	<input type="checkbox"/> CPAP machine	<input type="checkbox"/> syringes
<input type="checkbox"/> oxygen concentrator	<input type="checkbox"/> nebulizer	<input type="checkbox"/> cane or walker
<input type="checkbox"/> wound care dressings	<input type="checkbox"/> ostomy appliances	<input type="checkbox"/> Other:

Care Needs:

<input type="checkbox"/> no assistance needed	<input type="checkbox"/> assistance bathing	<input type="checkbox"/> assistance needed to dress
<input type="checkbox"/> care plan prescribed by MD	<input type="checkbox"/> assistance toileting	<input type="checkbox"/> wound dressing assistance
<input type="checkbox"/> assistance eating	<input type="checkbox"/> assistance turning at night	<input type="checkbox"/> other:

Medications (please list all medications you will bring on pilgrimage and attach additional list, if needed)

Drug:	Dose/Frequency:	Reason for taking drug:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Assistance needed with medications? Yes No
 Does medication require refrigeration? Yes No

Please continue on reverse side ⇨

Health History - check current and past conditions (include dates):

CURRENT / PAST	CURRENT / PAST	CURRENT / PAST
<input type="checkbox"/> <input type="checkbox"/> abnormal blood pressure	<input type="checkbox"/> <input type="checkbox"/> bladder incontinence	<input type="checkbox"/> <input type="checkbox"/> abuse victim
<input type="checkbox"/> <input type="checkbox"/> arthritis	<input type="checkbox"/> <input type="checkbox"/> bleeding disorder	<input type="checkbox"/> <input type="checkbox"/> depression
<input type="checkbox"/> <input type="checkbox"/> asthma	<input type="checkbox"/> <input type="checkbox"/> blood-born (HIV, Hepatitis, etc.)	<input type="checkbox"/> <input type="checkbox"/> eating disorder
<input type="checkbox"/> <input type="checkbox"/> eyesight impairment	<input type="checkbox"/> <input type="checkbox"/> bowel incontinence	<input type="checkbox"/> <input type="checkbox"/> fear of enclosed spaces/crowds
<input type="checkbox"/> <input type="checkbox"/> diabetes: insulin-dependent	<input type="checkbox"/> <input type="checkbox"/> cancer: _____	<input type="checkbox"/> <input type="checkbox"/> mental/emotional disorder
<input type="checkbox"/> <input type="checkbox"/> diabetes: non insulin-dependent	<input type="checkbox"/> <input type="checkbox"/> heart disease	<input type="checkbox"/> <input type="checkbox"/> nervous system disorder
<input type="checkbox"/> <input type="checkbox"/> dizziness	<input type="checkbox"/> <input type="checkbox"/> intestinal disorder: _____	<input type="checkbox"/> <input type="checkbox"/> Post-Traumatic Stress Disorder
<input type="checkbox"/> <input type="checkbox"/> hearing impairment	<input type="checkbox"/> <input type="checkbox"/> musculoskeletal disorder	<input type="checkbox"/> <input type="checkbox"/> psychotherapy
<input type="checkbox"/> <input type="checkbox"/> hernia	<input type="checkbox"/> <input type="checkbox"/> open wounds, ulcers or sores	<input type="checkbox"/> <input type="checkbox"/> recent loss of a loved one
<input type="checkbox"/> <input type="checkbox"/> nosebleeds	<input type="checkbox"/> <input type="checkbox"/> respiratory disorder: _____	<input type="checkbox"/> <input type="checkbox"/> substance abuse
<input type="checkbox"/> <input type="checkbox"/> seizure disorder	<input type="checkbox"/> <input type="checkbox"/> spinal injury, surgery or disease	<input type="checkbox"/> <input type="checkbox"/> pregnant: due date: _____
<input type="checkbox"/> <input type="checkbox"/> speech impairment	<input type="checkbox"/> <input type="checkbox"/> stroke	<input type="checkbox"/> <input type="checkbox"/> Other (Celiac, Crohn's, etc): _____

Have you had Covid-19: No Yes If yes, please list date: _____

Are you vaccinated against Covid-19? No Yes If yes, indicate which: _____ Date: _____

Will you be vaccinated before travel? No Yes Not sure

Further describe conditions checked above: acute chronic stable improving declining

Date and reason for surgeries/hospitalizations:

Date and reason last seen by physician:

Current therapies: none physical respiratory speech counseling other:

Traveling: alone with a relative with a friend or companion Relationship:

Co-traveler's name: Phone: ()

Co-traveler to provide: all care needs some care needs none (Lourdes Volunteers to provide care needs)

Primary Care Physician: _____ City: _____ State: _____

Telephone: () Fax: ()

Do you have a Health Care Proxy (i.e., DNR): Yes No **Advance Directives attached**, if applicable

(Health Care Proxy Name, if applicable)

Emergency Contact Name: Relationship:

Home Phone: () Cell: () Work: ()

Email:

(not traveling with you)

Secondary Contact Person: Relationship:

Home Phone: () Cell: () Work: ()

Email:

Printed Name:

Signature/Date: