PRIVATE & CONFIDENTIAL

Our Lady of Lourdes Hospitality
North American Volunteers, LTD.

Health INFORMATION

2021

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:

Home Phone:( )	Cell:( )	Email:

☐ Male ☐ Female	Height:	Weight:	Age:	Birth: Month / Day / Year

*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? ☐ Yes ☐ No

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

- ☐ fully able to walk
- ☐ able to walk short distance
- ☐ able to go up/down stairs
- ☐ unable to walk
- ☐ use a manual wheelchair
- ☐ provide a wheelchair for me
- ☐ use of stairs with assistance
- ☐ use a cane or walker
- ☐ fully able to sit and stand
- ☐ sit/stand with limits/assistance
- ☐ fully able to bend and lift
- ☐ bending and/or lifting restrictions
- ☐ unable to bend

wheelchair model: **weight:** **folded measurement**: *length x width x height*

Durable Medical Equipment Use/Supplies *(please list all equipment or supplies you will travel with):*

- ☐ none
- ☐ feeding pump
- ☐ oxygen concentrator
- ☐ wound care dressings
- ☐ Bi-Pap machine
- ☐ CPAP machine
- ☐ nebulizer
- ☐ ostomy appliances
- ☐ diabetes supplies
- ☐ syringes
- ☐ cane or walker
- ☐ Other:

Care Needs:

- ☐ no assistance needed
- ☐ care plan prescribed by MD
- ☐ assistance eating
- ☐ assistance bathing
- ☐ assistance toileting
- ☐ assistance turning at night
- ☐ assistance needed to dress
- ☐ wound dressing assistance
- ☐ 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
☐ ☐ abnormal blood pressure	☐ ☐ bladder incontinence	☐ ☐ abuse victim
☐ ☐ arthritis	☐ ☐ bleeding disorder	☐ ☐ depression
☐ ☐ asthma	☐ ☐ blood-born (HIV, Hepatitis, etc.)	☐ ☐ eating disorder
☐ ☐ eyesight impairment	☐ ☐ bowel incontinence	☐ ☐ fear of enclosed spaces/crowds
☐ ☐ diabetes: insulin-dependent	☐ ☐ cancer: _____	☐ ☐ mental/emotional disorder
☐ ☐ diabetes: non insulin-dependent	☐ ☐ heart disease	☐ ☐ nervous system disorder
☐ ☐ dizziness	☐ ☐ intestinal disorder:_____	☐ ☐ Post-Traumatic Stress Disorder
☐ ☐ hearing impairment	☐ ☐ musculoskeletal disorder	☐ ☐ psychotherapy
☐ ☐ hernia	☐ ☐ open wounds, ulcers or sores	☐ ☐ recent loss of a loved one
☐ ☐ nosebleeds	☐ ☐ respiratory disorder:_____	☐ ☐ substance abuse
☐ ☐ seizure disorder	☐ ☐ spinal injury, surgery or disease	☐ ☐ pregnant: due date: _____
☐ ☐ speech impairment	☐ ☐ stroke	☐ ☐ 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**: