**Health Form**

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| General Information |
| Event Name: |  |
| Event Dates: |  |
| Participant Name: |  |
| E-mail: |  |
| Date of Birth: |  | **Phone** |  | **Mobile** |  |
| Address: (Street, number, Zip Code, Town/City) |  |

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| Emergency Contact Details  |
| Name:  |  | **How are you related:** |  |
| Address: (Street, number, Zip Code, Town/City) |  |
| Phone Number: (Including Area Code) |  | **Mobile** |  |
| E-mail: |  |

Please notice that all visitors and volunteers must have International Health/Trip Insurance, before arriving to Our Cabana.

Our Cabaña is not responsible for any accident or illness that may occur while participating on any event.

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| Insurance Information  |
| Name of Health Insurance Company: |  |
| Membership Number/Policy Number: |  |
| Name of the Policy Holder: |  | **Phone** |  |
| Phone Number of the Company: |  |
| Address of the Company: |  |
| E-mail of the Company: |  |

It is really important for Our Cabana that this form is completed thoroughly.

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| Allergies |

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| Do you suffer or have you ever suffered from any of the following allergies: *(Mark with an X)* |
| Animals |  |
| Pollen |  |
| Plants / Grass / Flowers  |  |
| Medicine/Drugs (please specify) |  |
| Food |  |
| Chemicals |  |
| Insect stings/bites |  |
| Dust |  |
| Other:  |  |

If yes, please give details of your reaction and treatment:

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| Health History |

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| Do you suffer or have you ever suffered from any of the following conditions? *(Mark with an X)* |
| Fainting |  |
| Abnormal blood pressure |  |
| Hay fever  |  |
| Hearing impairment |  |
| Depression |  |
| Diabetes |  |
| Arthritis |  |
| Eyesight impairment |  |
| Speech impairment |  |
| Asthma |  |
| Epilepsy |  |
| Convulsions |  |
| Severe menstrual pain |  |
| Other:  |  |

If yes, please give details of usual treatment should and list any medication taken for this:

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Do you suffer from any other physical or emotional condition that would prevent you from participating fully? *(If so please give specific details*):

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Have you had any medical treatment or had major surgery in the past 2 years? *(If so please give specific details)*

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| Yes |  |
| No |  |

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| Medication |

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| Will you be taking any medication during the event *Please list medicines that are not the same you mentioned before)*

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| Immunizations |

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| When was your last immunization against Tetanus?

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List below other immunizations you have received:

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| Sprecial Diet |

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| If you have any special dietary requirements, please specify. *(Mark with an X)* |
| Vegetarian |  |
| Vegan |  |

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| Select any food you CAN’T eat *(Mark with an X)* |
| Chicken meat |  |
| Beef |  |
| Pork meat  |  |
| Fish |  |
| Eggs |  |
| Sugar |  |
| Gluten  |  |
| Dairy |  |
| Other:  |  |

If you have any allergies or intolerances to specific food or other special dietary requirement, please give details:

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Please give an example of a menu; you may have in regular basis:

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| BREAKFAST: |  |
| LUNCH: |  |
| DINNER: |  |
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Our Cabaña Staff will try to provide meals within your dietary requirement, however please be aware in some cases this can be difficult. To assist our catering staff, please provide any special food you may require which can be difficult to find in Mexico.

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| Release |

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| I, , as an adult participant and/or parent/guardian with legal custody of the above participant, understand that Our Cabaña – Guías de México A.C. and the World Association of Girl Guides and Girl Scouts are not responsible for any medical expenses that may be caused because of an accident or illness, that may occur during my/her/his visit to Our Cabaña. I’m also conscious of the risks that are inherent to the program and activities that will be develop during the event. |

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| **Participant Name:** |  |
| **Participant Signature:** |  |
| **Parent / Guardian Name:** |   |
| **Parent / Guardian Signature:** |   |
| **Date:** |   |

Return Form To

nuestracabana@guiasdemexico.org.mx

# subdirectora\_nc@guiasdemexico.org.mx