HAITI
ORPHANAGE
PROJECT
ESPWA

VOLUNTEERS MEDICAL CONSENT FORM

Volunteers must complete and sign this application form to allow for the release of their relevant medical information to the charities medical officer by their GP.

Travel will not be allowed for insurance reasons unless this form is received.

Volunteers must agree to update the charities medical officer of any change in their medical condition prior to travel including pregnancy.

The charities medical officer on behalf of the charity has the right to refuse permission for a volunteer to travel or to continue to participate in the trip if the medical officer deems the volunteer to be medically unfit.

We are a registered charity which works in partnership with Haitian Builders to renovate orphanages for the disadvantaged children in Haiti.

With the following in mind, please state whether your patient is medically fit to travel as a volunteer. The volunteer has signed this form as consent to allow the release of the relevant medical information to the medical officer of **Haiti Orphanage Project Espwa Limited.**

Flight duration is approximately ten hours each way. Transfer to the site is up to another six hours in a jeep and an hour's boat journey to the island.

Temperatures can be up to 45 degrees Celsius and 70% humidity.

Working days are from 6am to 6pm with two short breaks and the work is difficult due to the lack of machinery.

Serious medical conditions/injuries requiring hospital care will require medical evacuation via helicopter to the USA.

CONSENT:

I, , give my consent to release relevant medical information to the medical officer of Haiti Orphanage Project Espwa Limited.

Signature : Date:

Continued overleaf...

DOCTORS MEDICAL CERTIFICATE

Name:

Address:

Date of Birth:

Previous Medical History, (including in particular Cardiac/Respiratory/Psychiatric/Musculoskeletal/Neurological, Abdominal):

Recent operations or admissions to hospital:

Drug History:

Blood Group (if known):

Vaccinations:

I deem my patient to be medically **FIT/UNFIT** to participate in the volunteer experience.
(please delete as appropriate)

General Practioner:

Address:

Telephone No:

Signature: Date:

Form to be returned to: Dr. Helen Connolly, Carrigeen, Via Waterford, Co. Kilkenny.

CHY 19799