Operation Groundswell
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Personal Medical History

I __________________ hereby certify that I'm in good health and that my personal physician has determined that any existing medical condition(s) will not adversely affect my participation in an Operation Groundswell program in one of the following regions: Cambodia, Ecuador, Guatemala, India, Peru, Tanzania, or Thailand.

OG programs are mentally and physically challenging for many participants. Long haul bus travel, physical labour, physical activities including hiking and backpacking while carrying 40-60L are common realities on the ground. Some programs also involve living and working at altitude (upwards of 4,500m or 15,000ft) and/or in hot and humid environments (as high as 40°C or 104 °F plus humidity). Program groups are together for most of the day, and although there are some opportunities for free time, on-program personal space and time tend to be limited. Our team leaders are there to provide support beyond logistics, but are not trained medical professionals.

Even if conditions will not prohibit or restrict participation, it is vital that Operation Groundswell is made aware of them so that we can provide the proper support and background to our program leaders and to our participants.

Please read and answer all of the questions listed below before signing at the bottom. You are also required to visit your physician or a travel clinic to discuss any potential health risks related to the program and travel in general. You may submit this form to your institution or directly to Operation Groundswell at any time, but you are required to submit a new Medical History Form if anything changes prior to your departure.

Do you have any allergies (to food, insects, plants, medicines, etc.)? **Y / N**

If yes, please list and explain:

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Do you have any special dietary requirements? **Y** / **N**

If yes, please list and explain:

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Have you ever received, or are you currently receiving, medical treatment for any of the following illnesses? Please highlight/circle **Y**es or **N**o:

Frequent or severe headaches	**Y** / **N**
Head injury causing neurological impairment	**Y** / **N**
Weakened limbs or joints or broken bones	**Y** / **N**
Vision or hearing impairment or balance disorders	**Y** / **N**
Illegal substance or alcohol abuse	**Y** / **N**
Diabetes	**Y** / **N**
Hypoglycaemia (low blood sugar)	**Y** / **N**
Brain or neurological disorders, epilepsy, seizures, stroke, paralysis, or multiple sclerosis	**Y** / **N**
Blood disorder or anaemia	**Y** / **N**
Hepatitis	**Y** / **N**
Tuberculosis or positive TB test	**Y** / **N**
Dizziness, blackouts, fainting spells, or loss of consciousness for any reason	**Y** / **N**
Blood disorder or anaemia	**Y** / **N**
High or low blood pressure	**Y** / **N**
Heart disease or vascular problems, heart murmur or irregular heartbeat, history of angina or chest pain	**Y** / **N**
Stomach, liver, esophageal or intestinal problems	**Y** / **N**
IBS or related illnesses	**Y** / **N**
Current pregnancy	**Y** / **N**
Lung disease, recurrent lung infections, chronic cough, breathing problems, or asthma	**Y** / **N**

Anorexia, bulimia, or EDNOS **Y** / **N**

Thyroid disease **Y** / **N**

Kidney disease **Y** / **N**

Endocrine disorders **Y** / **N**

Orthopaedic problems **Y** / **N**

Motion sickness **Y** / **N**

Sleep walking **Y** / **N**

Behavioural, psychological or mental health issues such as depression, anxiety, or panic attacks **Y** / **N**

Phobias such as fear of flying, fear of heights, fear of enclosed spaces **Y** / **N**

Intolerance of cold or hot temperatures **Y** / **N**

Anaphylaxis **Y** / **N**

Other illness or injury **Y** / **N**

If you have answered yes to any of the above conditions, please explain below:

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Do you have any physical or behavioural conditions that may affect or limit your full participation in all aspects of the program? **Y** / **N**

If yes, please list and explain:

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Will you be required to take any prescription medications during the program? **Y / N**

If yes, please list and explain:

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Physician's Signature:

I understand the conditions of the program, confirm that the above medical history and information is true and accurate, and give the above-named participant medical clearance to participate in this program:
Physician's Signature: ___________________________

Printed Name: ___________________________

Date: _____________________

Participant's Signature:

I understand that as a team member in an Operation Groundswell program I may enter into situations that are both physically and mentally demanding, but I have consulted with and been cleared by a physician to engage in all prescribed activities, except as noted above. The medical history I have provided is true to the best of my knowledge, and I agree to accept responsibility for any errors, omissions, or failures to disclose relevant information to Operation Groundswell. I understand that if I fail to disclose any relevant medical information it will render null and void any contract conditions or terms agreed upon with Operation Groundswell.

Participant's Signature: ___________________________

Printed Name: ___________________________

Date: _____________________