



Confidential Health Form

Note: Providing false, misleading and/or incomplete information may seriously endanger the health of a participant and is grounds for his/her dismissal from the AMIGOS program. Participant files, including medical forms, are considered confidential and information is released by the International Office on a need-to-know basis only.

There are two sections to the Confidential Health Form. The applicant must complete Section I before giving this form to his/her health care providers. Section II of the Confidential Health Form must be completed by your primary care physician. If during the past two years you received outpatient mental health, inpatient psychiatric, or chemical dependency services, a copy of this form must also be completed by those treating clinicians. It is important that your physician/clinician be aware of the rural, sometimes under-developed conditions in which participants may live and indicate any condition that may affect your participation. Any additional forms your physician/clinician(s) wish to use may be attached; however, this form must also be completed in full. Disclosure of a medical condition does not automatically disqualify an applicant from admission to the program, but may result in further screening to determine appropriateness for AMIGOS service.

SECTION I (To be completed by the applicant and his/her parents)

Participant Name _____ Gender: _____ Date of Birth: ____/____/____

Weight: _____ lb. Height: _____ e-mail: _____

Cell Phone number (or home phone if no cell phone): _____

Health Insurance: All participants are required to carry health insurance that covers injury and illness while participating in the AMIGOS Service Programs. Please complete the following information:

Health Insurance Carrier: _____ Policy/ID #: _____

Phone Number: _____

Note: AMIGOS provides a supplemental, short-term, international health insurance policy, which will cover medical expenses not covered by the participant's primary insurance policy while in Latin America up to \$100,000. This policy does not cover care in the U.S. or the participant's country of origin and does not cover pre-existing conditions. Participants must carry a primary health insurance policy for medical expenses not covered by the AMIGOS supplemental policy and for follow-up care when they return home. Expenses not covered by the AMIGOS supplemental policy will be entirely the responsibility of the participant and his/her family.

1. Have you ever sought professional help for a psychological or behavioral problem? Yes No
If yes, please explain:

2. During the past two years have you received any of the following health care services?
If yes, please document dates and a brief description of the treatment you were provided:

Outpatient mental health services: Yes No

Dates: _____ Reason: _____

Inpatient psychiatric services: Yes No

Dates: _____ Reason for hospitalization: _____



Participant's Name: _____

Are you currently, or have you within the past 2 years, taken prescribed medication for a psychological or behavioral problem? Yes No

If yes, please document dates and the specific drug with dosage taken.

Chemical dependency services: Yes No

Dates: _____ Reason: _____

3. Do you have any other health condition (physical or mental) that may need to be taken into consideration in-country or in making your program assignment? Yes No

If yes, please explain:

4. If you are currently under treatment for any condition(s) mentioned above, please provide the name and telephone number of the treating clinician(s).

Note: If you answered "yes" to any of the above, Section II of the Confidential Health Form must also be completed by each treating clinician.

I hereby certify that the information provided in Section I of the Confidential Health Form is complete and accurate. I understand that submission of inaccurate and/or incomplete information about my medical and/or emotional health history may result in my dismissal from the AMIGOS program. I agree that if any substantial change should occur in my medical and/or emotional health prior to my departure for training and Latin America Service Program locations, I will also inform AMIGOS in writing immediately. I further agree that I will sign a release form with my treating clinician(s) to allow the exchange of information with authorized AMIGOS representatives.

Note: If the Participant is under 18 years of age, at least one custodial parent or legal guardian must sign this release.

Participant's Signature: _____ Date: _____

Signature of Parent (or Legal Guardian): _____ Date: _____