HOPE FOUNDATION

MEDICAL STATEMENT

ECUADOR - MANTA - LIGÜIQUI

PROGRAMA

VOLUNTARIADO LIGÜIQUI

DATOS GENERALES

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HOPE FOUNDATION MEDICAL STATEMENT

IMPORTANT – PLEASE READ

The Ligüiqui community is located on the top of a cliff that is approximately 100m above sea level, which allows it to have special characteristics both in climate and in the colorful landscape that surrounds it, because of its privileged location it is surrounded by various types of vegetation from dry to wet forest which harbor a variety of insects and wild animals associated with these places. Ligüiqui Beach is the most isolated beach of Manta, it is located about 35 km from the center of Manta and is surrounded by deep cliffs from where the views of the Pacific Ocean are spectacular. Its proximity to both the wildlife and marine reserve of Pacoche and San Lorenzo Beach, makes Ligüiqui an ideal stop to discover a small fishing village full of history and archaeological remains.

The volunteer program consists of aquatic and land activities to be carried out during the volunteer stay. Since the activities take place in places where there is interaction with the surrounding wildlife, the chances of an accident or a situation requiring immediate assistance from the volunteer may increase. In this context, Hope Foundation uses the following questionnaire to make you aware of these conditions before participating in any hiking activity, extraction of terrestrial or marine survey material, snorkeling or scuba breathing activities that may jeopardize your health, your safety and the safety of anyone with whom you may interact in the future.

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before coming to participate in the volunteer program. A positive answer to a question does not necessarily disqualify you for the land and sea activities we will be conducting during your stay. A positive answer means that there is a pre-existing medical condition that may affect your safety and that you MUST consult a doctor before participating in the activities to be performed. The physician must sign at the bottom of the form to say that he/she does not find any incompatible medical condition by checking any "YES" box. Please answer the following questions about your past or present medical history by checking the box marked "YES" or "NO". If you are not sure, answer YES.

NAME OF VOLUNTEER : _____

		YES	NO
1	**Medication:** Do you regularly take any over-the-counter or prescription medication? If yes, please specify.		
2	**Allergies:** If you have any allergies (food or non-food related). If yes, please specify (specific foods, medications, environmental, dust, pollen, etc.).		
3	**Mental and Mood Conditions:** Current mental illness or mood disorder or history of mental illness or mood disorder, including but not limited to schizophrenia, paranoid disorder, hysterical attacks. If yes, please specify.		
4	**Neurological Conditions:** Including, but not limited to, history of seizure disorder, stroke, brain surgery, repeated fainting or blackouts, severe migraine headaches, or aneurysm of cerebral blood vessels. If yes, please specify.		
5	**Cardiovascular Conditions:** Including, but not limited to, myocardial infarction, cardiac surgery, irregular heart rhythm, pacemaker, uncontrolled high blood pressure. If yes, please specify.		
6	**Pulmonary Conditions:** Including, but not limited to, asthma, history of spontaneous collapsed lung, collapsed lung due to injury, cysts or air pockets in the lungs, severe lung tissue damage, emphysema, any lung problem that interferes with your ability to breathe. If yes, please specify.		
7	**Ear, nose and throat Conditions:** Including, but not limited to, tumors, polyps or cysts of the sinus cavities or nasal passages, major sinus surgery, persistent sinus infection, permanent holes in the eardrums, history of ruptured eardrum, permanent tubes in the eardrums, severe hearing impairment or hearing loss in one or both ears, major ear surgery. If yes, please specify.		
8	**Eye Conditions:** Including, but not limited to, severe myopia, retinal detachment, eye surgery. If yes, please specify.		
9	**Diabetes Mellitus:** Type I (insulin-dependent) diabetes or Type II diabetes, which requires insulin or oral medication for control. Any form of Diabetes that is unstable, "brittle" or produces episodes of hypoglycemia (low blood sugar reactions), hyperglycemia (extremely high blood sugar with ketosis) or if there is related kidney, eye, heart or vascular disease. If yes, please specify.		
10	**Freediving/Scuba Diving History:** Including, but not limited to, history of diving accident, severe blackout, decompression sickness, inner ear decompression of air, reverse blockage, lung compression, any lung compression resulting in pink foam, pulmonary hemorrhage. If yes, specify.		
11	**General Medical Problems:** Any physical and/or emotional condition not mentioned that may affect your safety in an underwater environment or affect your judgment in times of physical or emotional stress. If yes, please specify.		
12	**Pregnancy:** If you are presently pregnant.		

Please provide any additional information regarding your allergies or medical history that you feel is important for the host family and program organizers to know:

_____

_____

Physician to complete (If any "YES" box from page 1 was ticked)

☐ I find no medical conditions that I consider incompatible with the activities that will be performed during the stance.

☐ I am unable to recommend this individual with the activities that will be performed during the stance.

Name of the volunteer: _____

Physician's Name: _____

Physician's Signature: _____

Date: _____

Physician's phone number: _____

Physician's Stamp or Postal Address: _____

My signature on the above verifies that I have completely reviewed this applicant's Medical Statement and find no counter/indications for the activities from the volunteer program to be carried out during the stay in Ligüiqui, Ecuador.

I certify that I have answered the above questions accurately and honestly.
I am responsible for omission regarding my failure to disclose any current or past health condition.

Name of Volunteer: _____

Signed: _____

Date of Birth*: _____

Date: _____

*If the Volunteer is a minor, this must also be signed by a parent/guardian

Name of the parent or guardian: _____

Address of the parent or guardian: _____

Contact number of the parent or guardian: _____

Signature of participant's parent or guardian: _____