CARIBBEAN AWARD SUB-REGIONAL COUNCIL
CASC ADVENTUROUS JOURNEY 2009

JAMAICA
JULY 30 – AUGUST 16, 2009

CODE NAME: "ONE LOVE"

PASSPORT SIZE PHOTO HERE. Do not put a staple across the picture

MEDICAL FORM

Name: (Surname)______________________________(First Name)______________________________

Nationality ______________________________ Age: ____ ☐ Married ☐ Single

Pulse rate: ______/80 Gender: ☐ M ☐ F Height: ________(m) Weight: _______ (kg)

Religion: ______________________________ Blood Group: ______________

Occupation: ____

Address: ____

____

Tel: Home: ______________ Cell: ______________ Work: ______________

Name of Next of Kin: ______________________ Relation: ______________

Next of Kin Address: ____

____

Next of Kin (Home): ____________ Cell: __________ Work: ______________

Have you been Vaccinated/ Immunized against any of the following? If yes, give dates

		Date			Date
Diphtheria	☐ Yes ☐No	__________(yy/mm/dd)	Rubella	☐ Yes ☐No	__________yy/mm/dd)
Tetanus	☐ Yes ☐No	__________(yy/mm/dd)	Yellow Fever	☐ Yes ☐No	________(yy/mm/dd)
Measles	☐ Yes ☐No	__________(yy/mm/dd)	Mumps	☐ Yes ☐No	________(yy/mm/dd)
Polio	☐ Yes ☐No	__________(yy/mm/dd)	Hepatitis	☐ Yes ☐No	________(yy/mm/dd)

Do you suffer from any of the following? State date of last attack or medical change.

	Date		Date
Diabetes	__________(yy/mm/dd)	Epilepsy	__________(yy/mm/dd)
Hypertension	__________(yy/mm/dd)	Heart Disease	__________(yy/mm/dd)
Rheumatic Fever	__________(yy/mm/dd)	Asthma	__________(yy/mm/dd)
Other	__________(yy/mm/dd)		

List all current and ongoing medication. Ensure that you have an adequate supply of medication with you.

____

Do you have any Allergies to Foods, Medicines, Pollens, Mites, Dust and Additives? If yes, please explain.

____

Have you been in contact with or suffered any contagious illness within the last six (6) months? If yes, please explain.

____

Have you recently traveled to an area of endemic or epidemic disease? If yes, please state the nature of such disease or travel.

____

When was your last dental check up ____________________ (yy/mm/dd)
(If you haven't had a check up within the last six (6) months, please have one done.)

Has your vision been checked lately and do you have any special visual requirement
☐ Yes ☐ No ____

Do you have any special dietary requirement for medical or religious purpose. If yes, please explain if you are lactose intolerant or a vegetarian.
☐ Yes ☐ No ____

Have you had surgery or any medical disability with recent times, ex. Fractures, Hernias, Appendicitis. If yes, please explain.
☐ Yes ☐ No ____

I hereby acknowledge that the information contained with this document is accurate as stated and true upon the time of being signed

Signed: ____________________________________ Date: ____________________
Applicant (yy/mm/dd)

Signed: ____________________________________ Date: ____________________
Parent/Guardian (yy/mm/dd)

MEDICAL RELEASE (IMPORTANT)

In the event of my child/ward is faced with any life-threatening medical condition (eg. Appendicitis). I______________________________ here by give consent ☐; do not give consent ☐ (*please tick appropriate box*) to the Expedition Leader/National Director/Chairman or any of their representatives the authority to sign any medical forms for any appropriate medical procedure that may be deemed necessary to deal with such conditions.

Signed: ____________________________________ Date: ____________________
Applicant / Parent/Guardian (if a minor) (yy/mm/dd)

Completed forms are to be submitted to the National Award Authority of Jamaica

The Duke of Edinburgh's Award Jamaica
2 Waterloo Road
Kingston 10
Jamaica, West Indies
Tel: 1 (876) 929-9546; Cell: 1 (876) 578-4031; Fax: 1 (876) 968-6218
Email: cascjm@jmaward.org / Website: http://jmaward.org