



Meningitis Angels

After Meningitis Health Research Form

POBox 448 * Porter, Texas* 77365 * Attention F. Milley

For More Information e-mail fmilley@aol.com

Thank You in Advance for your help with this project.

It is our hope to encourage more education and research and one day eradicate this disease.

We are collecting data on the after health of Bacterial Meningitis Survivors (Earth Bound Angels). Data will be collected through, December 2006. All the information collected will be made available to physicians, health research facilities and government bodies for study. To participate, you must fill out all pages of this form and sign and notarized and return to the address above.

NOTE!!! If you have a Non Survivor (Heaven Bound Angel) we would like to encourage you to participate. Please fill out the below form as it applies to your angel.

This is also important information.

Form must have your signature or parents/guardians signature for minor child giving Meningitis Angels permission to use for study/distribution to helping agents. And all pages must be initialed at the top left hand corner and must be notarized.

Do you think vaccine should be given to all who request it ___or routinely__ or not at all___

Research Form

Please Fill Out Completely

Date of Death ___/___/___ if applicable.

Name of Applicant ___ or ___ Deceased	
Name of Parent or Legal Guardian _____	
Relation to Applicant if other than self _____	
Age of applicant ___ Birth Date ___/___/___	
Address _____	City _____ State _____ ZipCode _____
Phone Numbers Day _____	Night _____ Cell _____
E-Mail address _____	Web Site _____
(ONLY fill Out if) Information of Relation is different from Applicant	
Address _____	City _____ State _____ ZipCode _____
Phone Numbers Day _____	Night _____ Cell _____
E-Mail address _____	Web Site _____
The following information helps us to tract types of meningitis and related causes. This information is vital to education and research of this disease and vaccines. We appreciate all your help. Thank You	
Type of Bacterial Meningitis _____ Viral _____	
Serogroup if applicable _____	Was Applicant Vaccinated Yes___ No___ ?
If so when and for what kind of meningitis ?	(Explain) _____
Date of Illness ___/___/___ Age ___	Are they vaccinated now? Yes___ No___?
How long was Applicant hospitalized? ___ day ___ weeks ___ months. ICU Yes ___ No ___	
In a rehabilitation hospital? ___ day ___ weeks ___ months. Are they still in hospital or rehab unit? Yes___ No___	
Do you know the source of the disease? No___ If Yes___ Please Explain Below	
Were there other cases in your area? Yes___ No ___ I f Yes,	
How long ago ___ days ___ weeks ___ months and how many cases ___?	
Does Applicant smoke or exposed to smokers or second hand smoke ? No___ Yes___	
If yes explain _____	
Did Applicant have other health problems or chronic or recent illness prior to disease? No___ Yes___ If Yes please explain. Was on going treatment involved including medications, surgery or hospitalization involved? Yes___ No___ If yes please explain and give list of medications.	

Had anyone ever told you about meningitis or the prevention including vaccines ? No___ Yes ___
 If yes please explain _____

What was the last activity applicant was involved in before the onset of illness?

Was applicant up to date on all other immunizations Yes___ No___ If no please explain

List Disabilities from the disease: Check all which apply

Amputations Circle One or Both	Right ~Left toe/s___ foot___ leg/s _____	Right~ Left finger/s___ hands___ arm/s	Nose__ ear/s___
Organ Damage	Right ~ Left Eye/s	%_____ Right ~ Left	Ear/s %_____

Check all that apply

Kidney/s Right ~Left	Spleen_____ Liver_____	Skin___% on 1~5___ Scale 5 being the worst.	Brain Damage ___
Lose of taste____ smell___ memory loss ___body functions	motor skills___ ability to walk___ talk____ social skills _____	<u>Do you have</u> mood swings ___temper tantrums ___seizures___	migraines scale from 1~5 (5) being extreme ___depression ___ blood problems___ joint pain__

Was one or more transplant/s preformed ? No___ Yes___ Explain

Please list any other problems not listed here. _____,

Are you taking life long medications because of your meningitis. No ___ If ___ Yes Please list
 medications and how long you have to
 take. _____,

Since the disease have you developed other diseases or illnesses. No___ If ___yes please
 explain what and how long after meningitis? _____days _____ weeks___ months ___years

PLEASE NOTE

Meningitis Angels, does not discriminate against anyone who meets the requirements of the organization. Hands on services, grants, and materials are limited to those victims under age 18 years old unless a full time student up to age 21.

ALL services are based on funding and resources at the time of application.

All services or helps may not be of equal value.

Assistance with a funeral NOTE!! Meningitis Angels should be contacted prior to ANY arrangements being made. Contacting us afterwards may limit or prevent our ability to help you.

FOR OFFICE USE ONLY

Name of Applicant

Grants/Services/Materials given

Dollar amount of service/materials given.

Approved by the board of directors and placed into

action date ___/___/___.

Signature of Board Members and Directors

See minutes attached by e-mail or in person vote.

_____, **president**

_____, **vice presidents**

_____	,secretary
_____	,treasurer
_____	, managing director

Keep going

ATTACH Copy of Medical Records

Place Photo of Angel Here >	
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Complete Medical Information Release

I _____ being said applicant or the legal parent or guardian of applicant do hereby give my permission to release all medical records to Meningitis Angels Heaven and Earth Bound, Inc. and it's assignees to use any and all of this information on the herein on the attached forms, deemed by Meningitis Heaven and Earth Bound, Inc. to be useful for grant, assistance, public education, research and any proper use deemed necessary including all media and publications, by Meningitis Angels Heaven and Earth Bound, Inc.

I hold harmless all board members and directors from liability of use or reproduction.

I _____ swear all information given here is

true and I am legally qualified by law to give it for **myself** ,
_____ **or Name of**
Applicant _____ if minor or mentally incompetent.
(Attach Copy Legal Power of Attorney) and release and approve use of said
information, documents or pictures etc. to Meningitis Angels Heaven and Earth Bound,
Inc. _____.

Signature _____

Print Name _____

Notary Public

I _____ **swear before me on this** ____ **day of**
_____ **in the year** _____. **The above person**
_____ **appeared before me and signed this document.**

Signature of Notary Public _____

Notary SEAL HERE

If you have any questions or need more information> please contact with the information on page 1