

5. Medical Treatment

Please specify any condition that is currently under treatment by a doctor.

What medication are you taking at this time?

Do you or have you ever received any compensation for disability, from any source?

Yes No

Please specify

6. Communicable Disease

Have you ever had any of the following?

Yes No

- Chickenpox
- Measles (Rubella)
- Measles (Rubeola)
- Mumps
- Pertussis
- Scarlet Fever
- Tuberculosis
- Others (specify)

7. Family History

Have any of your relatives ever had any of the following?

	Yes	No
	Relationship (eg father)	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
Stomach disease	<input type="checkbox"/>	<input type="checkbox"/>

8. Are you currently addicted to cigarette, any kind of tobacco products or alcohol?

Yes No

If yes, please explain

9. Have you ever experimented with or been addicted to illegal drugs? Yes or No

If Yes, please explain the type of drugs, length of use, date last used and treatment, including any ongoing treatment.

We have a policy of no illegal drugs, smoking, use of any tobacco product or the abuse of alcohol at anytime during the six-month school. You will need to stop smoking, using any tobacco products or abusing alcohol a minimum of one month before your arrival. We will need references who can verify this as well as a signed agreement that you will be sent home at your own expense if this problem persists.

Any use of illegal drugs will need to stop immediately and you must undergo treatment if this has become an addiction before you will be considered for this program. References and a signed agreement will also be needed. Any use of illegal drugs during the DTS will be cause for immediate dismissal.

Physician's Evaluation

TO THE PHYSICIAN : The applicant has applied for a school with Youth With A Mission. Can you please review the information on the applicant's confidential Health Form and complete this section of the form.

1. Physical Assessment
Height (cm)

Blood pressure

Hearing : Right

Vision
Uncorrected Right

Corrected : Right

Weight (Kg)

Left

Left

Left

2. Are there any abnormalities of the following systems?

	Yes	No
Head, ear, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Nervous System	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Trunk & Back	<input type="checkbox"/>	<input type="checkbox"/>
Digestive tract	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Urogenital	<input type="checkbox"/>	<input type="checkbox"/>

If the answer was "Yes" to any of the previous questions please describe fully below or on a separate piece of paper.

3. Does the applicant have any physical or psychological disorder that would limit their ability to participate fully in studies or field assignments, locally or overseas?

4. Physician's recommendation for follow-up test / treatments

5. Physicians' recommendation (please tick)

- Acceptable without limitations
- Acceptable with limitations (specify below)
- Not acceptable
- Should remain in areas where adequate medical care is provided.

6. Immunization History

	Date		Date
Typhoid		Pertussis	
Polio		Diphtheria	
Rubella		Diphtheria	
Mumps		Yellow fever	
BCG		Hepatitis	
Tetanus		Hepatitis B	

7. Physician's Name

Address/ Stamp

Signature

The Portion of the form below must be filled out and signed by a physician

TURBERCULOSIS CONTROL (required for entrance by YWAM – Tampa)

One of the following:

	Date	Result	Examination Facility
Chest X-Ray			
Skin Test			
BCG Vaccination			

Physician's Signature _____

Date : _____

Day /Month/Year

Physician's Name (please print) _____

Address _____