



Youth With A Mission

G R E N A D A

Sauteurs, St. Patrick's, Grenada, W.I.

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Website: www.ywamgrenada.org

Confidential Health Forms

Name of applicant: _____

Course applied for: Discipleship Training School (DTS)

In emergency, contact: _____ Phone: _____

Medical insurance company: _____ Insurance number: _____

Personal history

Please mark any of the following conditions that you have had, or currently have:

Skin conditions	Head Injury	Hepatitis
Eye trouble	Shortness of breath	Intestinal trouble
Ear trouble	Hey fever/ asthma	Recurrent diarrhea
Recurrent headache	Heart trouble	Diabetes
Epilepsy	High blood pressure	Kidney disease
Fainting spells	Low blood pressure	Anaemia
Mental/nervous disorders	Back problems	Venereal disease
Weakness	Rheumatism/ arthritis	HIV virus
Paralysis	Dislocation of joints Broken bones	Tumor; cancer
Insomnia	Eating disorders	
Allergies: Penicillin	Anorexia nervosa	
Sulfonamides	Bulimia	WOMEN ONLY
Serum	Stomach/ duodenal ulcer	Irregular periods
Other drugs — specify below	Gall bladder problems	Severe cramps
Foods — specify below	Jaundice	Excessive flow
Other — specify below	Surgery— specify below	Pregnant: number of weeks _____

Other — please specify allergies/ conditions: _____

Please explain any of the conditions that are marked: _____

Are you now under a doctor's care for any condition? No Yes If Yes, please specify _____

Are you taking any medication at this time? No Yes If Yes, please specify: _____

Any physical handicaps or health conditions which requires special attention? No Yes If yes, please specify:

Do you have a history of emotional instability or psychiatric treatment? No Yes if Yes , please specify:

Are you overweight? Underweight? Pounds over/under: _____ Blood group: _____

Would you rate your health condition as: excellent good fair poor

Communicable diseases — if you have had any of the following please mark:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles (Rubella) | <input type="checkbox"/> Measles (Rubella) | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Other (specify) _____ |

Family history — please mark any medical conditions that are part of your family history:

- | | Relationship | | Relationship |
|--|--------------|--|--------------|
| <input type="checkbox"/> Tuberculosis | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Hypertension | _____ | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Convulsions, epilepsy | _____ | <input type="checkbox"/> Kidney disease | _____ |
| <input type="checkbox"/> Heart disease | _____ | <input type="checkbox"/> Asthma, hay fever | _____ |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Stomach disease | _____ |

To the Physician

Name of applicant: _____

The above person has applied for service with Youth With A Mission. This program will require good health and endurance. Please review the applicant's health information contained in this paper, complete the section below, and make any additional comments. Thank you.

Blood pressure: _____ Pulse: _____ Height: _____ Weight: _____

Are there any abnormalities of the following system? If yes, please describe.

Ear, nose, throat _____

Eyes _____

Neurological _____

Cardiovascular _____

Respiratory _____

Musculoskeletal _____

Would the applicant be able to walk three to four miles a day? yes no

Physician's recommendation:

The applicant is: acceptable without limitations not acceptable
 should remain in areas where adequate medical care is available acceptable with limitations (please specify)

Doctor's signature _____ Date _____

Doctor's name (please print) _____

Full address (please print) _____