

Confidential Health Form

1. Name			
	First	Middle	Last/Family Name
Do you hav	ve medical insuran	ce? Yes No	
If yes, nam	e of insurer:	Policy nu	umber:
Name of Po	olicy Holder:		
2. Persona	al History:		
Height:	Weight:	Blood Type:	_ Ever had a reaction to blood products?
Please ans	swer all of the ques	tions and in the space p	rovided please comment on any questions with
a "Yes" ans	swer. Have you ev	er had, or do you have, a	any of the following:

	Yes	No
Eating Disorders		
Eye Trouble		
Ear Trouble		
Head injury		
Recurrent Headache		
Epilepsy		
Fainting Spells		
Weakness		
Paralysis		
Insomnia		
Broken Bones		
Dislocation of Joints		
HIV Positive		
Hepatitis A, B or C (specify)		
Stomach/Duodenal Ulcer		
Jaundice		
Intestinal Trouble		
Recurrent Diarrhea		

	Yes	No	Comments:
Back Problems			Comments.
Hay Fever/ Asthma			
Skin Conditions (specify)			
Shortness of Breath			
Anemia			
Heart Trouble			
High or Low Blood Pressure			
Rheumatism/ Arthritis			
Chronic Constipation			
Diabetes			
Kidney Disease			
Venereal Disease			
Tumor/Cancer			
Counseling of any kind? (specify)			

Email: registrar@ywamwylie.org

Phone: (972) 429-9278



Confidential Health Form (cont.)

Allergic Reactions to:

	Yes	No
Penicillin		
Sulphonamides		
Foods/Other (specify)		

Surgery:

	Yes	No
Appendectomy		
Tonsillectomy		
Hernia repair		
Other (specify)		

Females Only:

	Yes	No
Irregular Periods		
Severe Cramps		
Excessive Flow		
Are You Pregnant?		

If you answered "yes" to any of the above questions, please comment below:				

If yes, p	al/Nervo lease giv treatmer	e details	including	g treatmen	t and

4. Medical Treatment

pecify any condition that is currently unde t by a doctor.	r
	_
	_
	_
	_
	_
	_
	_

Do you or have you ever received any compensation for disability from any source?					
•	•	Please specify:			

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Confidential Health Form (cont.)

5. Communicable Diseases

Have you ever had any of the following:

	Yes	No		
Chickenpox				
Measles (Rubella)				
Mumps				
Pertussis				
Scarlet Fever				
Tuberculosis				
Other (Specify)				
If Other, please specify what communicable disease you had or currently have that is not mentioned:				

6. Family History

Have any of your relatives had any of the following:

	Yes	No	Relationship (e.g father)		
Arthritis					
Asthma/Hay Fever					
Cancer					
Diabetes					
Epilepsy/Convulsions					
Heart Disease					
HIV/AIDS					
Kidney Disease					
Mental Illness					
Stomach Disease					
Do you have any special dietary needs?					
Are you taking medication at this time? Yes: No: Please specify:					

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Confidential Health Form (cont.)

Applicant's full name:			-
Please attach a copy of your immunization records.			
To the Physician:			
The above named person has applied to participate in the volunteer missions program with Youth With A			
Mission. This is a short-term missionary service in which there may be some strenuous physical exertion. Please answer the following questions regarding the applicant's health.			
1. Would he/she be able to walk 3-4 miles per day?		Yes:	No:
2. Would you consider the applicant to be in good health?		Yes:	
3. Do you certify the applicant to be non-contagious?		Yes:	
4. 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? Yes: No:			
			140
Abnormalities: Are there any abnormalities of the following systems?			
	Yes		No
Head, Ears, Nose, Throat			
Eyes			
Teeth			
Nervous System			
Cardiovascular			
Respiratory			
Trunk or Back			
Digestive Tract			
Musculoskeletal			
Endocrine (thyroid)			
Skin			
Urogenital			
Doctor's signature or stamp:			
Doctor's full name printed:		Date	:
Full Address:			