YWAMWYLIE

Confidential Health Form

Name

First Name | Middle Name | Last Name

Do you have medical insurance?

- [ ] Yes
- [ ] No

Name of insurer

Policy number

Name of policy holder

Personal History

Height | Weight | Blood type

Have you ever had a reaction to blood products?

- [ ] Yes
- [ ] No

Please indicate if you currently or have ever experienced any of the following:

- [ ] Eating disorders
- [ ] Fainting spells
- [ ] Eye trouble
- [ ] Weakness
- [ ] Head injury
- [ ] Paralysis
- [ ] Recurrent headache
- [ ] Insomnia
- [ ] Epilepsy
- [ ] Broken bones
- [ ] Dislocation of joints
- [ ] Intenstinal problems

YWAM Wylie, PO Box 2787, Wylie, TX 75098

Email: Registrar@ywamwylie.org
Phone: (972) 429-9278

☐ HIV positive	☐ Recurrent diarrhea
☐ Hepatitis A, B, or C (specify)	☐ Back problems
☐ Stomach/duodenal ulcer	☐ Hay fever/asthma
☐ Jaundice	☐ Shortness of breath
☐ Anemia	☐ Diabetes
☐ Heart trouble	☐ Kidney disease
☐ High or low blood pressure	☐ Venereal Disease
☐ Rheumatism/arthritis	☐ Tumor/cancer
☐ Chronic constipation	☐ Counseling of any kind (specify)

If you marked any of the sections above, please explain:

Do you experience allergic reactions to:

Penicillin? ☐ Yes ☐ No

Sulphonamides? ☐ Yes ☐ No

Foods/other? ☐ Yes ☐ No Specify:

Have you received any of the following surgeries?

Appendectomy? ☐ Yes ☐ No

Tonsillectomy? ☐ Yes ☐ No

Hernia repair? ☐ Yes ☐ No

Other? ☐ Yes ☐ No Specify:

Females only, Do you experience:

Irregular Periods? ☐ Yes ☐ No

Severe cramps? ☐ Yes ☐ No

Excessive flow? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If you answered yes to any of the sections above, please explain:

Do you have a mental/nervous disorder?

- [ ] Yes
- [ ] No

If yes, please give details including any past treatment or ongoing treatment and any problems:

Are you currently receiving any medical treatment?

- [ ] Yes
- [ ] No

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

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

- [ ] Yes
- [ ] No

If yes, please specify:

Have you ever had any of the following:

Chicken pox? ☐ Yes ☐ No Pertussis? ☐ Yes ☐ No

Measles (Rubella)? ☐ Yes ☐ No Scarlet fever? ☐ Yes ☐ No

Mumps? ☐ Yes ☐ No Turberculosis? ☐ Yes ☐ No

Other? ☐ Yes ☐ No Specify:

Family History

Have any your relatives had any of the following:

	Yes	No	Relationship
Arthritis			
Asthma/Hay fever			
Cancer			
Epilepsy/Convulsions			
HIV/AIDS			
Kidney Disease			
Mental Illness			
Stomach Disease			

Do you have any special dietary needs?

Are you currently taking any medication? Please specify:

Physician Report

Applicant's Name

First Name Middle Name Last Name

Please attach a copy of your immunization records.

To the Physician:

The above named person has applied to participate in a 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.

Would he/she be able to walk 3-4 miles per day? ☐ Yes ☐ No

Would you consider the applicant to be in good health? ☐ Yes ☐ No

Do you certify the applicant to be non-contagious? ☐ Yes ☐ No

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

If yes please specify:

Are there any abnormalities of the following systems? Please indicate all that apply

☐ Head, Ears, Nose, Throat	☐ Respiratory
☐ Eyes	☐ Torso or back
☐ Teeth	☐ Digestive tract
☐ Nervous system	☐ Musculoskeletal
☐ Cardiovascular	☐ Endocrine (thyroid)
☐ Skin	☐ Urogenital

Doctor's signature or stamp: _____

Doctor's full name printed: _____ Date: _____

City, State, Phone number: _____

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