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HEALTH FORM (P-003) - PART A

TO THE APPLICANT: This information is treated confidentially and separate from your academic records. When you complete the first part of this form, please answer all questions in ink or by typing IN ENGLISH.

- 1. Course/Position Applying for: \_\_\_\_\_ Starting Date: \_\_\_\_\_
- 2. NAME: \_\_\_\_\_
- 3. U.S. Social Security Number/Canadian SIN: \_\_\_\_\_
- 4. Citizen of: \_\_\_\_\_
- 5. Permanent Address: \_\_\_\_\_

*Permanent Address*

*Telephone*

- 6. Do you have medical insurance?  Yes  No
- 7. Name of Insurer: \_\_\_\_\_
- 8. Med. Insurance No.: \_\_\_\_\_
- 9. Medical Insurance Coverage (briefly): \_\_\_\_\_
- 10. Name, Relationship and Address of Next of Kin: \_\_\_\_\_
- \_\_\_\_\_
- 11. Phone Number(s): \_\_\_\_\_
- 12. Person to contact in case of emergency: \_\_\_\_\_

*Last Name*

*First Name*

*Relationship*

*Address*

*Phone No.*

13. PERSONAL HISTORY Please answer all questions. Comment on all positive answers in the space below or on a separate sheet. Have you ever had, or do you have, any of the following?

- |                             |  |               |  |
|-----------------------------|--|---------------|--|
| Skin Conditions             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low blood pressure          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye trouble   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recurrent diarrhea          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear trouble   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Intestinal troubles         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head injury   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Broken bones                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgery       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dislocation of joints       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting spells             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back problems               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tumor/Cancer                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Paralysis     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recurrent headache          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Insomnia      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever, Asthma           | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV positive  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia repair | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatism/Arthritis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillectomy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gall bladder problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Appendectomy  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach/Duodenal Ulcer      | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Mental or nervous disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Allergies (specify): _____  |  |               |  |
| Other (specify) : _____     |  |               |  |

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FEMALES ONLY

Are you pregnant? [ ] Yes [ ] No Irregular periods [ ] Yes [ ] No
Severe cramps [ ] Yes [ ] No Excessive flow [ ] Yes [ ] No

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Other illnesses or conditions: \_\_\_\_\_

Are you at present under the doctor's care for any condition?
[ ] No [ ] Yes (specify) \_\_\_\_\_

Are you taking any medication at this time? [ ] No [ ] Yes
Specify: \_\_\_\_\_

Are you allergic to any drugs? [ ] No [ ] Yes
Specify: \_\_\_\_\_

Do you have a history of emotional instability or psychiatric treatment?
[ ] No [ ] Yes Specify: \_\_\_\_\_

Do you now or have you ever received any compensation for disability
from any source? [ ] No [ ] Yes Specify: \_\_\_\_\_

Do you have any physical impairments, handicaps, or health conditions which require special
attention? (Your response to this question will not affect admission consideration.)
[ ] No [ ] Yes If yes, please describe \_\_\_\_\_

Are you:
Underweight? [ ] No [ ] Yes If so, by how much? \_\_\_\_\_
Overweight? [ ] No [ ] Yes If so, by how much? \_\_\_\_\_
Blood type: O, A, B, AB (+ or -) \_\_\_\_\_

Would you rate your health condition as:
[ ] Excellent [ ] Good [ ] Fair [ ] Poor

Have you ever had any of the following:

COMMUNICABLE DISEASES? Specify:
Skin Conditions [ ] Yes [ ] No Head injury [ ] Yes [ ] No
High blood pressure [ ] Yes [ ] No Eye trouble [ ] Yes [ ] No
Low blood pressure [ ] Yes [ ] No Heart trouble [ ] Yes [ ] No
Rheumatism/Arthritis [ ] Yes [ ] No Ear trouble [ ] Yes [ ] No

FAMILY HISTORY Have any of your relatives ever had any of the following?
Skin Conditions [ ] Yes [ ] No Head injury [ ] Yes [ ] No
High blood pressure [ ] Yes [ ] No Eye trouble [ ] Yes [ ] No
Low blood pressure [ ] Yes [ ] No Heart trouble [ ] Yes [ ] No
Rheumatism/Arthritis [ ] Yes [ ] No Ear trouble [ ] Yes [ ] No

IMMUNIZATIONS

Basic Booster       No  Yes Year(s) \_\_\_\_\_  
 Diphtheria         No  Yes Year(s) \_\_\_\_\_  
 Tetanus             No  Yes Year(s) \_\_\_\_\_  
 Pertussis          No  Yes Year(s) \_\_\_\_\_  
 Polio               No  Yes Year(s) \_\_\_\_\_  
 Rubella             No  Yes Year(s) \_\_\_\_\_  
 Rubeola            No  Yes Year(s) \_\_\_\_\_  
 Mumps              No  Yes Year(s) \_\_\_\_\_

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HEALTH FORM (P-003) PART B - DOCTOR'S REPORT

The portion of the form below this line must be filled out and signed by a Physician.

TUBERCULOSIS CONTROL (absolutely required for entrance by YWAM - RUSSIA)

X-Ray

<i>Date</i>	<i>Result</i>	<i>Examination Facility</i>

Skin Test

<i>Date</i>	<i>Result</i>	<i>Examination Facility</i>

BCG Vaccination

<i>Date</i>	<i>Result</i>	<i>Examination Facility</i>

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Day/Mo/Yr*

Physician's Name (please print) \_\_\_\_\_

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