Confidential Health Form

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School applying for: ☐ **DTS** ☐ **EFM**

Starting Date: ____________________
Day/Month/Year

Applicant's Name

Last Name | First Name | Middle Name | Preferred Name

Permanent Address:

Street Address | City | State/Province | Postal/Zip Code | Country

Phone Number | Fax Number

Youth With A Mission Global Gateway requires that you have medical insurance coverage for the duration of your stay in Canada.
*** This includes any overseas outreach travels**

Name of Insurer: ____________________________

Brief Description of Medical Insurance Coverage:

PERSONAL HISTORY

Please answer all questions. Comment on all positive answers on a separate piece of paper.
Your response to these questions will affect admission consideration.

( ) Skin Conditions	( ) Eye Trouble	( ) Ear Trouble	( ) Head Injury	( ) Epilepsy
( ) Recurrent Headaches		( ) Fainting Spells	( ) Mental/Nervous Disorder	
( ) Weakness	( ) Paralysis	( ) Insomnia	( ) Shortness of Breath	
( ) Hay Fever/Asthma	( ) Heart Trouble	( ) High Blood Pressure		( ) Back Problems
( ) Low Blood Pressure		( ) Rheumatism/Arthritis		( ) Dislocation of Joints
( ) Broken Bones	( ) Ulcer (Specify)	( ) Gall Bladder Problems		( ) Surgery (specify)
( ) Jaundice	( ) Hepatitis	( ) Recurrent Diarrhea	( ) Kidney Disease	( ) Anemia
( ) Cancer (specify)	( ) Eating Disorders (specify)		( ) Allergies (specify)	( ) Diabetes

Females only

( ) Irregular Periods	( ) Severe Cramps	( ) Excessive Flow	( ) Are you pregnant?

Other illness or conditions: ______________________________

Are you (at present) under the doctor's care for any condition? ☐ Yes ☐ No (please specify:)

____

Are you talking any medication at this time? ☐ Yes ☐ No (please specify:)

____

Are you allergic to any drugs? ☐ Yes ☐ No (please specify:)

____

Do you have any food allergies? ☐ Yes ☐ No (please specify:)

____

YWAM CANADA GLOBAL GATEWAY

Do you have a history of emotional instability or psychiatric treatment? ☐ Yes ☐ No (please specify:)

Do you now or have you ever received any compensation for disability from any source? ☐ Yes ☐ No (please specify:)

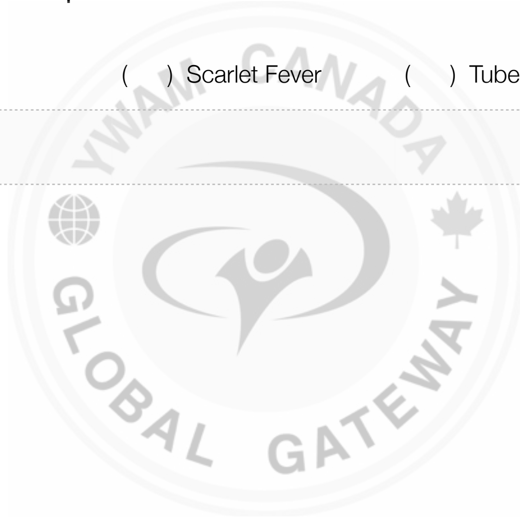
Do you have an physical impairments, handicaps or health conditions which require special attention? ☐ Yes ☐ No (please specify:)

COMMUNICABLE DISEASES: Please place a check mark beside the following illnesses you have had.

( ) Chicken Pox ( ) Mumps ( ) Scarlet Fever ( ) Tuberculosis

( ) Measles (specify:)

( ) Others (specify:)



TO THE PHYSICIAN

Name of the Applicant: ____

The above named person has applied for service with Youth With A Mission. This program will require good health, and endurance. **Applicants for the Personal Wellness DTS will be participating in physical exercise/activity 5 days week.** Please review the "Personal History" information, fill out the portion below, and make any additional comment. Thank you.

Blood Pressure:______________________________ Pulse:______________________________

Height: ______________________________ Weight: ______________________________

Are there any abnormalities of the following?

Yes	No		Please Describe:
☐	☐	Ears, Nose, Throat	______________________
☐	☐	Eyes	______________________
☐	☐	Neurological	______________________
☐	☐	Cardiovascular	______________________
☐	☐	Respiratory	______________________
☐	☐	Musculoskeletal	______________________

Would the applicant be capable of walking 5-6 kilometres per day?

☐ ☐ (please comment) ______________________________

How would you rate the applicant's condition of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

IMMUNIZATIONS

Are the following immunizations current?

Please answers Y(Yes) or N(No)

( ) DTP (Diphtheria, Tetanus, Pertussis) ( ) Poilio ( ) RRM (Rubella, Rubeola, Mumps)

( ) Cholera ( ) Typhoid ( ) Hepatitis A and B

YWAM CANADA GLOBAL GATEWAY

PHYSICIAN'S RECOMMENDATION

☐ Acceptable without limitations

☐ Should remain in areas where adequate medical care is provided

☐ Not acceptable

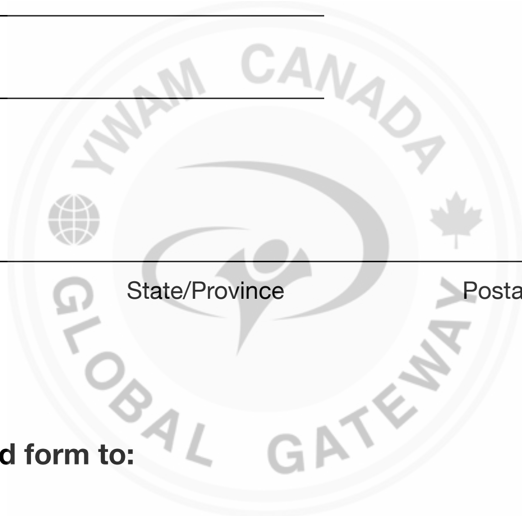
☐ Acceptable with limitations (specify) ____________________

Physician's Signature ____________________

Date ____________________

Physician's Name ____________________

Full address



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Street Address | City | State/Province | Postal/Zip Code | Country

Please Mail or Fax the completed form to:

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