

# CONFIDENTIAL HEALTH FORM

Name: \_\_\_\_\_  
Last/Family Name
First
Middle

Address: \_\_\_\_\_  
Street Address
City
State
Zip Code

School: \_\_\_\_\_  
School Applying For
Location
Dates

**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?**

	Yes	No		Yes	No		Yes	No
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>	Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder issues	<input type="checkbox"/>	<input type="checkbox"/>
Other-specify	<input type="checkbox"/>	<input type="checkbox"/>	Other-specify	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal troubles	<input type="checkbox"/>	<input type="checkbox"/>
Food-specify	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation of joints	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or	<input type="checkbox"/>	<input type="checkbox"/>
Ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Duodenal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headache	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Mental or nervous	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	disorders	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			
Hay Fever, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>		
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tumor: Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Do you have any special dietary needs? \_\_\_\_\_

Are you now under doctor's care for any condition?  Yes  No (specify) \_\_\_\_\_

Are you taking medication at this time?  Yes  No (specify) \_\_\_\_\_

Do you have any handicaps?  Yes  No (please describe) \_\_\_\_\_

Are you underweight? \_\_\_\_\_ Overweight? \_\_\_\_\_ If so, by how much? \_\_\_\_\_

**To The Physician:**

The above-named person has applied for service 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 generally good health?  Yes  No
3. Do you certify the applicant to be non-contagious?  Yes  No

## Vaccination Record

In order to help the planning process for your outreach phase, we would like to know if you have had the following vaccinations and if they're up to date.

Vaccination	Date of last shot
Tetanus/Diphtheria	
MMR (Measles, Mumps, Rubella)	
Polio	

The following vaccinations are not essential, but beneficial for certain outreaches and it is helpful for us to have the information.

Vaccination	Date of last shot	Check here if series was completed
Hepatitis A (Series of 2 shots)		
Hepatitis B (Series of 3 shots)		
Typhoid		
Yellow Fever		

If you have been given any additional shots, please list below.

Vaccination	Date of last shot

NOTE: Please use the space below to make additional comments regarding the applicant's health or special limitations affecting physical, mental or emotional capabilities.

Doctor's signature or stamp \_\_\_\_\_

Doctor's full name printed \_\_\_\_\_ Date: \_\_\_\_\_

Full Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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