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	☑	☐	Surgery	☐	☐	Jaundice	☐	☐
Penicillin	☐	☐	Appendectomy	☐	☐	Hepatitis	☐	☐
Sulfonamides	☐	☐	Tonsillectomy	☐	☐	Kidney Disease	☐	☐
Serum	☐	☐	Hernia repair	☐	☐	Gall bladder issues	☐	☐
Other-specify	☐	☐	Other-specify	☐	☐	Intestinal troubles	☐	☐
Food-specify	☐	☐	Broken bones	☐	☐	Recurrent diarrhea	☐	☐
Skin conditions	☐	☐	Dislocation of joints	☐	☐	Shortness of breath	☐	☐
Eye trouble	☐	☐	Rheumatism/Arthritis	☐	☐	Stomach or		
Ear trouble	☐	☐	Back problems	☐	☐	Duodenal Ulcer	☐	☐
Recurrent headache	☐	☐	Paralysis	☐	☐	Mental or nervous		
Fainting spells	☐	☐	Head injury	☐	☐	disorders	☐	☐
Insomnia	☐	☐	Epilepsy	☐	☐			
Hay Fever, Asthma	☐	☐	Anemia	☐	☐	**FEMALES ONLY**		
Heart trouble	☐	☐	Diabetes	☐	☐	Irregular periods	☐	☐
High blood pressure	☐	☐	Tumor: Cancer	☐	☐	Severe cramps	☐	☐
Low blood pressure	☐	☐	Venereal Disease	☐	☐	Hysterectomy	☐	☐
Weakness	☐	☐	Contagious Disease	☐	☐	Are you pregnant?	☐	☐

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: _____

Gleanings For The Hungry
P.O. Box 309
Sultana, CA 93666
dts@gleanings.org