APPLICATION FOR CHILDREN AT RISK & MUSIC DISCIPLESHIP TRAINING SCHOOLS

Confidential Health Form

TO THE STUDENT: This information is treated confidentially and separate from your academic records. Answer all questions in ink or by typing. Arrange with physician to complete **Physician's Evaluation**. Medical forms are also required for all accompanying dependents 16 years and older.

1. The school/outreach I wish to attend is:

Commencement date of school/outreach:

2. Your Name

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname

First Name

3. Personal History - Please answer all of the questions and comment on all questions with a "**Yes**" answer in the space provided below.

Have you ever had, or do you have, any of the following?

	Yes	No
Eating Disorders	☐	☐
Eye Trouble	☐	☐
Ear Trouble	☐	☐
Head Injury	☐	☐
Recurrent Headache	☐	☐
Epilepsy	☐	☐
Fainting Spells	☐	☐
Weakness	☐	☐
Paralysis	☐	☐
Insomnia	☐	☐
Allergic reactions to:		
Penicillin	☐	☐
Sulphonamides	☐	☐
Foods/Other (specify)	☐	☐
Hay fever/Asthma	☐	☐
Skin Conditions (specify)	☐	☐
Shortness of breath	☐	☐
Heart trouble	☐	☐
Anaemia	☐	☐
High or low blood pressure	☐	☐
Rheumatism/Arthritis	☐	☐
Back problems	☐	☐
Dislocation of joints	☐	☐
Broken bones	☐	☐
Surgery	☐	☐
Appendectomy	☐	☐
Tonsillectomy	☐	☐
Hernia repair	☐	☐
Other (specify)	☐	☐
HIV positive	☐	☐
Hepatitis A,B or C (specify)	☐	☐
Stomach/Duodenal Ulcer	☐	☐
Jaundice	☐	☐
Intestinal trouble	☐	☐
Recurrent Diarrhoea	☐	☐
Chronic constipation	☐	☐
Diabetes	☐	☐
Kidney disease	☐	☐
Venereal disease	☐	☐
Tumour/Cancer	☐	☐
Counselling of any kind?(specify)	☐	☐
FEMALES ONLY		
Irregular periods	☐	☐
Severe cramps	☐	☐
Excessive flow	☐	☐
Are you pregnant	☐	☐

If you answered "Yes" to any of the above questions please describe in the field below

4. Mental/Nervous Disorders

Have you ever had any mental or nervous disorders of any kind (for example but not limited to: depression, eating disorder, anxiety, bi-polar etc.)

Yes ☐ **No** ☐

If yes, please give details on a separate sheet including treatment and ongoing treatment, medication (past and/or present), counselling etc.

5. Medical Treatment

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 ☐

Please specify

6. Communicable Diseases

Have you ever had any of the following:

	Yes	No
Chickenpox	☐	☐
Measles (Rubella)	☐	☐
Measles (Rubeola)	☐	☐
Mumps	☐	☐
Pertussis	☐	☐
Scarlet Fever	☐	☐
Tuberculosis	☐	☐
Other (specify).....	☐	☐

7. Family History

Have any of your relatives ever had any of the following?

	Yes	No	Relationship (eg father)
Arthritis	☐	☐	_____
Asthma, Hay fever	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Epilepsy/Convulsions	☐	☐	_____
Heart disease	☐	☐	_____
HIV/AIDS	☐	☐	_____
Kidney disease	☐	☐	_____
Mental illness	☐	☐	_____
Stomach disease	☐	☐	_____

Physician's Evaluation

TO THE PHYSICIAN: The applicant has applied for a school with Youth With A Mission. Can you please review the information on the applicant's Confidential Health Form and complete this section of the form.

Please return completed form to: dts@arkintl.org.

Physical Assessment

Height (cm) | Weight (Kg)

Blood Pressure

Hearing: Right | Left

Vision

Uncorrected: Right | Left

Corrected: Right | Left

1. Are there any abnormalities of the following systems?

	Yes	No
Head, ears, nose, throat	☐	☐
Eyes	☐	☐
Teeth	☐	☐
Nervous system	☐	☐
Cardiovascular	☐	☐
Respiratory	☐	☐
Trunk & Back	☐	☐
Digestive tract	☐	☐
Musculoskeletal	☐	☐
Endocrine (thyroid)	☐	☐
Skin	☐	☐
Urogenital	☐	☐

If the answer was "Yes" to any of the previous questions please describe below or on a separate piece of paper

2. Does the applicant have any history of psychological or mental/nervous disorders, conditions that you are aware of, have treated: (for example but not limited to: depression, eating disorder, anxiety, bi-polar)

3. 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?

4. Physician's recommendation for follow-up test/treatments

Please attach on a separate sheet of paper as needed

5. Physician's recommendation (please tick)

- ☐ Acceptable without limitations
- ☐ Acceptable with limitations (specify below)
- ☐ Not acceptable
- ☐ Should remain in areas where adequate medical care is provided

6. Immunisation History

	Date		Date
Typhoid	_____	Cholera	_____
Polio	_____	Pertussis	_____
Rubella	_____	Diphtheria	_____
Mumps	_____	Yellow Fever	_____
BCG	_____	Hepatitis	_____
Tetanus	_____	Hepatitis B	_____

7. Physician's Name Date:

Address/Stamp

Signature

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