YOUTH WITH A MISSION PERTH

Staff

Confidential Health Form

TO THE APPLICANT: This information is treated confidentially and separate from your academic records. Answer all questions in ink or by typing IN ENGLISH. 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:

day / month / year

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.

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

	NO	YES
Eating Disorders	☐	☐
Eye Trouble	☐	☐
Ear Trouble	☐	☐
Head Injury	☐	☐
Recurrent Headache	☐	☐
Epilepsy	☐	☐
Fainting Spells	☐	☐
Weakness	☐	☐
Paralysis	☐	☐
Insomnia	☐	☐
Broken bones	☐	☐
Dislocation of joints	☐	☐
HIV positive	☐	☐
Hepatitis A,B or C (specify)	☐	☐
Stomach/Duodenal Ulcer	☐	☐
Jaundice	☐	☐
Intestinal trouble	☐	☐
Recurrent Diarrhoea	☐	☐
Back problems	☐	☐

Question 3 (continued)

	NO	YES
Hay fever/Asthma	☐	☐
Skin Conditions (specify)	☐	☐
Shortness of breath	☐	☐
Anaemia	☐	☐
Heart trouble	☐	☐
High or low blood pressure	☐	☐
Rheumatism/Arthritis	☐	☐
Chronic constipation	☐	☐
Diabetes	☐	☐
Kidney disease	☐	☐
Venereal disease	☐	☐
Tumour/Cancer	☐	☐
Counseling of any kind? (specify)	☐	☐

ALLERGIC REACTIONS TO:

Penicillin	☐	☐
Sulphonamides	☐	☐
Foods/Other (specify)	☐	☐

SURGERY

Appendectomy	☐	☐
Tonsillectomy	☐	☐
Hernia repair	☐	☐
Other (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

If yes, please give details including treatment and ongoing treatment/problems:

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:

	NO	YES
Chickenpox	◯	◯
Measles (Rubella)	◯	◯
Measles (Rubeola)	◯	◯
Mumps	◯	◯
Pertussis	◯	◯
Scarlet Fever	◯	◯
Tuberculosis	◯	◯
Other (specify)	◯	◯

If Other, Please Specify what communicable disease you had or currently have that is not mentioned:

7. Family History

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

	NO	YES	**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.

1. Physical Assessment

Height (cm)

Weight (Kg)

Blood Pressure

Hearing

Left

Right

Vision

Uncorrected

Left

Right

Corrected

Left

Right

2. Abnormalities

Are there any abnormalities of the following systems?

	NO	YES
Head, ears, nose, throat	○	○
Eyes	○	○
Teeth	○	○
Nervous System	○	○
Cardiovascular	○	○
Respiratory	○	○
Trunk and Back	○	○
Digestive Tract	○	○
Musculoskeletal	○	○
Endocrine (thyroid)	○	○
Skin	○	○
Urogenital	○	○

If the answer was "Yes" to any of the previous questions please describe below:

3. Physical/Psychological Disorder

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

Please write your recommendation for follow-up test/treatments:

5. Physician's Recommendation (please check)

- ○ 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
Thypoid		Cholera	
Polio		Diphtheria	
Rubella		Pertussis	
Mumps		Yellow Fever	
BCG		Hepatitis	
Tetanus		Hepatitis B	

7. Physician's Name

Date:

day / month / year

Address Stamp

Signature