DISCIPLESHIP TRAINING SCHOOL
CONFIDENTIAL HEALTH FORM

To be filled out by the applicant

Name _____Applying for _____

Please answer all personal history questions. Explain any "yes" answers in the spaces below.
Have you EVER had or do you CURRENTLY have any of the following?

	Yes	No
Skin Conditions	O	O
Eye trouble	O	O
Ear trouble	O	O
Head injury	O	O
Recurrent headache	O	O
Epilepsy	O	O
Fainting spells	O	O
Mental disorders	O	O
Nervous disorders	O	O
Weakness	O	O
Paralysis	O	O
Insomnia	O	O
Allergy	O	O
Penicillin	O	O
Sulphonamides	O	O
Serum	O	O
Other Specify	O	O
Foods Specify	O	O
Chicken pox	O	O
Measles	O	O

	Yes	No
Shortness of breath	O	O
Hay fever, Asthma	O	O
Heart trouble	O	O
High blood pressure	O	O
Low blood pressure	O	O
Rheumatism	O	O
Arthritis	O	O
Back problems	O	O
Dislocation of joints	O	O
Broken bones	O	O
Eating disorders	O	O
Anorexia nervosa	O	O
Bulimia	O	O
Surgery	O	O
Appendectomy	O	O
Hernia repair	O	O
Tonsillectomy	O	O
Others specify	O	O
Scarlet fever	O	O
Tuberculosis	O	O

	Yes	No
Stomach ulcer	O	O
Gall bladder problems	O	O
Jaundice	O	O
Hepatitis	O	O
Intestinal trouble	O	O
Recurrent diarrhea	O	O
Diabetes	O	O
Kidney disease	O	O
Anemia	O	O
Venereal disease	O	O
Tumor/ cancer	O	O
Females only	O	O
Irregular periods	O	O
Severe cramps	O	O
Excessive flow	O	O
Are you pregnant?	O	O
Previous pregnancies	O	O
Mumps	O	O
Other (Specify)	O	O

Other specify_____

Are you under a doctor's care for any condition? **O** yes **O** no
Please explain_____

Are you taking medication at this time? **O** yes **O** no
Please explain_____

Do you have any physical handicaps which require special attention? **O** yes **O** no
Please explain_____

Are you overweight? **O** yes **O** no Are you underweight? **O** yes **O** no

Blood type _____

How would you rate your overall health? **O** Excellent **O** Good **O** Fair **O** Poor

Signed _____ **Date** _____

DISCIPLESHIP TRAINING SCHOOL
CONFIDENTIAL PHYSICIAN FORM

To be filled out by a physician

Applicant Name _____ Applying for _____

The above person has applied for service with Youth With A Mission.
This program will require good health and endurance.
Feel free to make any additional comments.

Blood pressure _____ **Pulse** _____

Are there any abnormalities of the following systems?

		Please describe:
Eyes	O yes O no	_____
Ears, nose, throat	O yes O no	_____
Neurological	O yes O no	_____
Cardiovascular	O yes O no	_____
Respiratory	O yes O no	_____
Musculoskeletal	O yes O no	_____

Would he/she be able to walk 3-4 miles per day? O yes O no
Please attach any additional comments to this sheet.

Physician recommendation

O Acceptable without limitations
O Should remain in areas where adequate medical care is provided
O Acceptable with limitations (specify)

_____

O Not acceptable

Doctors name (printed)

_____

Doctors signature _____ Date _____

Full address

_____

Phone (_____) _____