

Course being applied for: \_\_\_\_\_

Student's name \_\_\_\_\_

Medical insurance company \_\_\_\_\_

Policy number \_\_\_\_\_

Course starting date: \_\_\_\_\_

## Personal History—Answer all questions, explaining any "yes" answers in the space provided.

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

	Yes	No		Yes	No		Yes	No
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever; asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headache	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal troubles	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Mental/nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation of joints	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia nervosa	<input type="checkbox"/>	<input type="checkbox"/>	Tumor; cancer	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>		
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>	Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>
Other—specify	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Food—specify	<input type="checkbox"/>	<input type="checkbox"/>	Others—specify	<input type="checkbox"/>	<input type="checkbox"/>	Previous pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis (whooping cough)	<input type="checkbox"/>	<input type="checkbox"/>
Measles (rubella)	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Other communicable diseases	<input type="checkbox"/>	<input type="checkbox"/>
Measles (rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	—specify which ones		

Other/explain \_\_\_\_\_

Are you now under doctor's care for any condition?  no  yes—If yes, explain: \_\_\_\_\_

Are you taking any medication at this time?  no  yes—If yes, specify: \_\_\_\_\_

Any physical handicaps or health conditions which require special attention?  no  yes—If yes, specify: \_\_\_\_\_

Do you have a history of emotional instability or psychiatric treatment?  no  yes—If yes, explain: \_\_\_\_\_

Are you  overweight?  underweight? Pounds over/under: \_\_\_\_\_ Blood type: \_\_\_\_\_

Would you rate your health condition as:  excellent?  good?  fair?  poor?

## Family History—Have any of your relatives ever had any of the following?

	Yes	No	Relationship to you		Yes	No	Relationship to you
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma; hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Convulsions; epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Consent for Treatment

Name of applicant \_\_\_\_\_

I/we hereby agree to the performance of such treatment, anesthetics, and operations as in the opinion of the attending physician is/are deemed necessary on the above-named person.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

(Required if applicant is under 18)

---

## Liability Release

I/we hereby release **Youth With A Mission, Inc.**, its staff, and volunteer assistants from any liability whatsoever arising out of any injury, damage, or loss which may be sustained by said person during the course of involvement with **Youth With A Mission, Inc.** I/we agree to resolve any and all disputes with **Youth With A Mission**, YWAM directors, or YWAM staff by means of reconciliation or arbitration; and waive any right to pursue action by way of litigation.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

(Required if applicant is under 18)

---

## Legal Consent for Minors

I hereby give my consent for \_\_\_\_\_ (complete name of minor) to travel outside the United States with Youth With A Mission.

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

(Required if applicant is under 18)

---

## To the Physician

Name of applicant \_\_\_\_\_

The above-named person has applied for service with Youth With A Mission. This program will require good health and endurance. Please review the "Personal History" information on the opposite side, fill out the portion below, and make any additional comments. Thank you.

Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Are there any abnormalities of the following systems?

	Yes	No	Please describe
Ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____

Would he/she be able to walk 3-4 miles per day? yes no

Comments \_\_\_\_\_

### Physician's recommendation:

Acceptable without limitations Should remain in areas where adequate medical care is provided

Not acceptable Acceptable with limitations (specify) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's name (printed) \_\_\_\_\_

Full mailing address \_\_\_\_\_