Mailing Address
PO Box 9186 National Mail Center
Piarco, Trinidad and Tobago, West Indies

Office: 1-868-669-8870
Email: info@ywamtt.com
Web: www.ywamtt.com

CONFIDENTIAL HEALTH FORM

Name of applicant: ____

Emergency contact: __________________________ Phone ______________________________

Medical Insurance Company: ____

Insurance Number: ____

PERSONAL HISTORY

Please mark any of the following that you have had or currently have:

- ☐ Skin conditions
- ☐ Head injury
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Eye Trouble
- ☐ Ear Trouble
- ☐ Recurrent Headaches
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Mental/nervous Disorder
- ☐ Weakness
- ☐ Paralysis
- ☐ Insomnia
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Rheumatism/ Arthritis
- ☐ Back problems
- ☐ Dislocation of joints
- ☐ Broken Bones
- ☐ Shortness of breath
- ☐ Hay fever/asthma
- ☐ Heart trouble
- ☐ Intestinal troubles
- ☐ Recurrent diarrhea
- ☐ Ulcer
- ☐ Gall bladder problems
- ☐ Eating disorder
- ☐ Anorexia nervosa
- ☐ Bulimia
- ☐ Anaemia
- ☐ Tumor/ cancer
- ☐ Venereal Disease
- ☐ HIV
- ☐ Surgery - Specify below
- ☐ Women only:
- ☐ Irregular Periods
- ☐ Severe cramps
- ☐ Excessive flow
- ☐ Pregnant: number of weeks _______

Allergies:

- ☐ Penicillin
- ☐ Sulfonamides
- ☐ Serum
- ☐ Other drugs - please specify
- ☐ Foods - please specify
- ☐ Insects - please specify
- ☐ Other - please specify

Other / Please explain conditions that you marked: ____
____

Are you now under a doctor's care for any condition? YES   NO

If yes, please specify:
____

Are you taking any medication at this time? YES   NO

If yes, please specify:
____

Any physical handicaps or health conditions that would require special attention? YES   NO

If yes, please specify: ____

Do you have a history of emotional instability or psychiatric treatment? YES   NO

If yes, please specify: ____

Are you

- ☐ Overweight
- ☐ Underweight

Pounds over/under (if known): ___________

Blood group (if known): __________

Would you rate your health condition as:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Communicable diseases - If you have had any of the following please mark:

- ☐ Chicken pox
- ☐ Pertussis
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Measles (rubeola)
- ☐ Scarlet fever
- ☐ German measles (rubella)
- ☐ Other (specify)

Family history - Please mark any medical conditions that are part of your family history:

- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Asthma
- ☐ Hypertension
- ☐ Cancer
- ☐ Stomach disease
- ☐ Convulsions, Epilepsy
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Arthritis

CONFIDENTIAL HEALTH FORM

TO THE PHYSICIAN

Name of the applicant ____

The above person has applied for service with Youth With A Mission. This program will require good health and endurance. Please review the applicant's health information above, complete the section below, and feel free to make any additional comments. Thank you.

Blood Pressure: ____
Pulse: ____
Height: ____
Weight: ____

Are there any abnormalities of the following system? If yes, please describe.
Ear, nose, throat: ____
Eyes: ____
Neurological: ____
Cardiovascular: ____
Respiratory: ____
Musculoskeletal: ____

Would the applicant be able to walk three or four miles a day? YES NO

Physician's Recommendation:

The applicant is

- ______ acceptable without limits
- ______ not acceptable
- ______ should remain in areas where adequate medical care is available
- ______ acceptable with limitations: ________________________________

Doctor's Name (please print) ____

Doctor's Signature ________________________________ Date ____________________________________

Doctor's Phone Number ____

Full Address (please print) ____

LIABILITY RELEASE / CONSENT FOR TREATMENT / LEGAL CONSENT FOR MINORS

Youth With A Mission is a volunteer missionary organization. Some of its work includes manual labour as well as going to countries where medical care and legal procedures may differ from the standards to which you are accustomed. With this in mind, we must ask you to be confident in your heart of the calling of God and to understand the sacrifice, which that may entail. By signing this form, you are giving your acknowledgement of these potential risks.

1) Liability: I hereby release Youth With A Mission Inc., its agents, employees and volunteer assistants from any liability whatsoever during the course of involvement with Youth With A Mission Inc.
2) Consent for Treatment: I hereby agree to such treatment, the attending physician deems anesthetics and operations as necessary.

Applicant Printed Name ____

Applicant's Signature ____

Date ____

(FOR APPLICANTS UNDER THE AGE OF 18)

Parent/Guardian's Signature ____

Date ____

Relationship of applicant ____