"Raising up transformed leaders in Haiti to impact the nations"

HEALTH FORM

TO THE APPLICANT: This health form is treated as confidential

Please circle one: Training Staff Volunteer Team

Name:_____ Date of Birth:_____

Address: _____

Email:_____ Phone:_____

Do you have medical insurance that covers you? Yes No

Provider:_____ Insurance Number: _____

Start Date:_____ _____ Expiry Date:_____

Person to contact in case of emergency:_____Relationship:_____

Address:_____

Email:_____ Phone: _____

Are you taking medications? (Please list): _____

Immunisations: (Please list all basic or last booster, or if you have a copy of records attach it separately)

Vaccination	**Year**	**Year**
Diphtheria		
Tetanus		
Pertussis		
Polio		
Rubella		
Rubeola		
Mumps		
Hepatitis A		
Hepatitis B		
Typhoid		

Personal History: (Please tick if ever had an issue with it)

Skin condition		Heart trouble		Jaundice	
Ear trouble		High blood pressure		Hepatitis	
Eye trouble		Low blood pressure		Retinal trouble	
Head injury		Rheumatism/arthritis		Headaches	
Back problem		Diabetes		Paralysis	

Epilepsy		Dislocation of joints		Kidney disease	
Fainting spells		Broken bones		Anaemia	
Mental disorders		Stomach/duodenal ulcer		Venereal disease	
Tumour/cancer		Insomnia		Shortness of Breath	

Mental Health & Addictions:

Please tick if you have or have previously had any of the following:

Alcohol Addiction		Drug Addiction		Eating Disorder	
Self Harm		Bipolar		Other	
Anxiety		Depression			

If 'Other' please explain: _____

Surgery:

Please list any surgeries you have undergone: _____

Allergies:
Please list any and all allergies including drugs, foods, chemicals, nature etc.

_____

Females Only:

Irregular periods		Severe cramps		Pregnant	

Communicable Diseases:
Please tick if you ever had any of the following:

Chicken Pox		Mumps		Tuberculosis	
Measles		Pertussis		Other	
Rubella		Scarlet fever			

If 'Other' please explain: _____

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

Diabetes		Arthritis		Cancer	
Kidney Disease		Stomach Disease		Asthma	
Heart Disease		Hypertension		Allergies/allergic reaction	
Tuberculosis		Epilepsy/Convulsions			

I _____(applicant) declare all the above information to be true to the best of my knowledge. I do not hold YWAM Cap-Haiti to be responsible for any injuries or illnesses sustained during my stay with YWAM Cap-Haiti. Should I require treatment or evacuation I am responsible for paying for this.

Signed:_____ Date:_____

For Trainee and Staff Applicants Only: To be filled out and signed by a physician

1) Can he/she walk up to 5 miles/8km per day carrying a 15pound/7kg backpack?
2) Is he/she underweight or overweight?
3) Is he/she under medical attention or taking medicine? If yes, please explain:
4) Is the applicant in general good physical health?
5) Is the applicant in general good mental health?
6) Does the applicant have any contagious illness?

Physician's signature: _____ Date: _____

Physician's name: _____ Phone: _____

Address: _____ Email: _____