



# YWAM HEREDIA, COSTA RICA

## Adult Confidential Health Form

This application is a fillable pdf. Please tab to each field to fill in information. Please save and send via email to YWAM Heredia ([jucumheredia@gmail.com](mailto:jucumheredia@gmail.com)) when you are finished. You can also print it off, fill it in, scan it and email to us.

### PERSONAL INFORMATION

Last name: First name: Middle name:

Nickname: Sex: Male Female Age:

Birthdate (mm/dd/yyyy): Birthplace:

Citizenship (Country):

Home Telephone: Cell Phone: Fax:

Email Address:

### Current Mailing Address

Street/Box:

City/Town: State: Zip: Country:

### Permanent Mailing Address

Street/Box:

City/Town: State: Zip: Country:

### PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Last name: First name:

Address:

City/Town: State: Zip: Country:

Relationship: Home Phone: Cell Phone:

Email:



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**NEXT OF KIN:**

Last name:

First name:

Address:

City/Town:

State:

Zip:

Country:

Relationship:

Home Phone:

Cell Phone:

Email:

Do you have medical insurance?    No    Yes    Name of Insurer:

Med. Ins. No.

Med. Insurance coverage (briefly):

Please answer all questions and take both Part A and Part B to your physician. Explain all positive answers. The omission of health history problems or incomplete explanation of the same can lead to removal of acceptance status.

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

- |   |                                 |   |                         |
|---|---------------------------------|---|-------------------------|
| N | Y - Skin Condition              | N | Y - Depression          |
| N | Y - Eye Trouble                 | N | Y - Paralysis           |
| N | Y - Ear Trouble                 | N | Y - Insomnia            |
| N | Y - Head Injury                 | N | Y - Shortness of Breath |
| N | Y - Recurrent Headaches         | N | Y - Hay fever/Asthma    |
| N | Y - Epilepsy                    | N | Y - Heart Trouble       |
| N | Y - Fainting Spells             | N | Y - High Blood Pressure |
| N | Y - Mental/Nervous Disorders    | N | Y - Low Blood Pressure  |
| N | Y - Allergies: Food (specific): |   |                         |

Other Allergies:    Bee Stings    Penicillin    Sulfonamides    Serum

**\*If you are allergic to bee stings, you must bring your own up-to-date reaction kit.**

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Have you ever had, or do you now have, any of the following: (continued)

- |                                    |                                  |
|------------------------------------|----------------------------------|
| N Y - Rheumatism/Arthritis         | N Y - Intestinal Troubles        |
| N Y - Back Problems                | N Y - Recurrent Diarrhea         |
| N Y - Dislocation of Joints        | N Y - Diabetes                   |
| N Y - Broken Bones                 | N Y - Kidney Disease             |
| N Y - Stomach/Duodenal Ulcer       | N Y - Anemia                     |
| N Y - Sexual Transmitted Disease   | N Y - Gall Bladder Problems      |
| N Y - Jaundice                     | N Y - Cancer/Tumors              |
| N Y - Hepatitis                    | N Y - Weakness                   |
| N Y - Surgeries:      Appendectomy | Tonsillectomy      Hernia Repair |

Other Type of Surgery: \_\_\_\_\_ Date (MM/YY): \_\_\_\_\_

Results: \_\_\_\_\_

Other Type of Surgery: \_\_\_\_\_ Date (MM/YY): \_\_\_\_\_

Results: \_\_\_\_\_

Other Type of Surgery: \_\_\_\_\_ Date (MM/YY): \_\_\_\_\_

Results: \_\_\_\_\_

### FAMILY HISTORY

Have any of your family members ever had any of the following?

- |                      |   |
|----------------------|---|
| N Y - Tuberculosis   | N Y - Arthritis Asthma, Hay Fever           |
| N Y - Diabetes       | N Y - Stomach Disease Epilepsy, Convulsions |
| N Y - Kidney Disease | N Y - Hypertension Cancer                   |
| N Y - Heart Disease  | N Y - Other (specify): _____                |

### COMMUNICABLE DISEASES

Have any of your family members ever had any of the following?

- |                               |                            |
|-------------------------------|----------------------------|
| N Y - Chicken Pox             | <b>FEMALES ONLY:</b>       |
| N Y - Measles (Rubella)       | N Y - Irregular Periods    |
| N Y - Measles (Rubeola)       | N Y - Severe Cramps        |
| N Y - Mumps                   | N Y - Excessive Flow       |
| N Y - Pertussis               | N Y - Are you pregnant?    |
| N Y - Scarlet Fever           | N Y - Previous pregnancies |
| N Y - Tuberculosis            |                            |
| N Y - OTHER: (specify): _____ |                            |



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Other illnesses or conditions:

Are you at present under a doctor's care for any condition?    No    Yes

Specify:

Are you taking any medication at this time?    No    Yes

Specify:

**PLEASE ARRANGE TO BRING ALL NECESSARY LONG-TERM MEDICATIONS WITH YOU**

Are you allergic to any drugs?    No    Yes

Specify:

Do you have a history of emotional instability or psychiatric treatment?    No    Yes

If "Yes", When                                      For how long:                                      Still in treatment?    No    Yes

Please explain:

**Do you have any history with:**

No    Yes Eating disorders?

If "Yes", When                                      For how long:                                      Still in treatment?    No    Yes

Please explain:

No    Yes Drug/alcohol abuse?

If "Yes", When                                      For how long:                                      Still in treatment?    No    Yes

Please explain:

No    Yes Sexual issues?

If "Yes", When                                      For how long:                                      Still in treatment?    No    Yes

Please explain:



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Do you now or have you ever received any compensation for disability from any source?

No Yes Specify:

Do you have any physical impairments, handicaps, or health conditions which require special attention?

No Yes Specify:

Have you been tested for HIV? No Yes If "Yes", what were the results? Neg Pos

**Your response to the above questions will not necessarily determine admission considerations.**

Do you wear contact lenses or glasses? No Yes Specify:

Please rate your health: Excellent Good Fair Poor

Additional information:



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### PART B: PHYSICIAN'S EVALUATION

Applicant's Name:

Date:

#### TO THE PHYSICIAN:

Please review the information in PART A. Please treat all conditions that you feel require treatment and notify us of any problems that you feel merit follow-up by the health service. Some conditions such as diabetes, epilepsy and heart disease may have an effect on the location of the applicant's outreach. Please ensure that any pertinent information in these areas has been included.

#### TO THE APPLICANT:

All required immunizations MUST BE COMPLETED BEFORE YOU WILL BE ACCEPTED AT YWAM-Heredia. Due to the varied outreach locations, other immunizations, injections and malaria medication may be required and can be obtained before outreach. If you have ever been vaccinated for cholera, typhoid, or yellow fever, please bring that information with you. Please be prepared financially to cover the cost of additional injections.

You need to have a Diphtheria-Tetanus booster within the last 5 years. If you were born after 1957, you will need a measles booster (total of 2 measles immunizations). Those born before 1957 are considered immune from measles.

#### CHILDHOOD RECORD OF IMMUNIZATIONS (BASIC)

	DD / MM / YY	DD / MM / YY	DD / MM / YY	DD / MM / YY
Diphtheria	/ /	/ /	/ /	/ /
Tetanus	/ /	/ /	/ /	/ /
Pertussis	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /
Rubella	/ /	/ /	/ /	/ /
Measles	/ /	/ /	/ /	/ /
Mumps	/ /	/ /	/ /	/ /



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### ADULT IMMUNIZATIONS BOOSTER

	DD / MM / YY	DD / MM / YY
Diphtheria	/ /	/ /
Tetanus	/ /	/ /
Pertussis	/ /	/ /
Polio	/ /	/ /
Rubella	/ /	/ /
Measles	/ /	/ /
Mumps	/ /	/ /

### TUBERCULOSIS CONTROL (within 6 months of the school)

One of the following:

#### Chest X-ray

Date:                      Result:                      Examination Facility:

#### Skin Test\*

Date:                      Result:                      Examination Facility:

**\*If your skin test is positive you MUST have a chest X-ray.**

Date of last DT (Diphtheria/Tetanus) booster:                      (must be within the last 5 years)

Height:              /              Weight:              Overweight:      No      Yes If yes, how much?

Blood Pressure:              Pulse:              Blood Type:

Visual Acuity (without glasses): R              L              (with corrective lenses) R              L

Urinalysis:    Last Pap Smear (not compulsory):



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Are there any abnormalities of the following systems? Please describe fully.

Ears/Nose/Throat:

Ophthalmological:

Teeth:

Neurological:

Cardiovascular:

Respiratory:

Musculoskeletal:

Endocrine:

Lymphatic:

Dermatological:

Hernial Orifices:

Urological:

Psychiatric:

Recommendations For Follow-up Tests / Treatment:

Would he/she be able to walk 3 – 4 miles per day?    No    Yes

Additional Comments:

How long has this patient attended your office?    Years                      Months                      Weeks





# **YWAM HEREDIA, COSTA RICA**

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### **PHYSICIAN'S RECOMMENDATION:**

Acceptable Without Limitations

Not Acceptable

Should Remain In Areas Where Adequate Medical Care Is Provided

Acceptable With Limitations (specify):

PHYSICIAN'S NAME: (print)

DATE:

ADDRESS:

PHONE:

PHYSICIAN'S SIGNATURE: