YWAM HEREDIA, COSTA RICA
Child 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) 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 - Eye Trouble
☐ N ☐ Y - Ear Trouble
☐ N ☐ Y - Head Injury
☐ N ☐ Y - Recurrent Headaches
☐ N ☐ Y - Epilepsy
☐ N ☐ Y - Fainting Spells
☐ N ☐ Y - Mental/Nervous Disorders
☐ N ☐ Y - Allergies: Food (specific): _____

☐ N ☐ Y - Depression
☐ N ☐ Y - Paralysis
☐ N ☐ Y - Insomnia
☐ N ☐ Y - Shortness of Breath
☐ N ☐ Y - Hay fever/Asthma
☐ N ☐ Y - Heart Trouble
☐ N ☐ Y - High Blood Pressure
☐ N ☐ Y - Low Blood Pressure

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 - Back Problems
- ☐ N ☐ Y - Dislocation of Joints
- ☐ N ☐ Y - Broken Bones
- ☐ N ☐ Y - Stomach/Duodenal Ulcer
- ☐ N ☐ Y - Sexual Transmitted Disease
- ☐ N ☐ Y - Jaundice
- ☐ N ☐ Y - Hepatitis
- ☐ N ☐ Y - Intestinal Troubles
- ☐ N ☐ Y - Recurrent Diarrhea
- ☐ N ☐ Y - Diabetes
- ☐ N ☐ Y - Kidney Disease
- ☐ N ☐ Y - Anemia
- ☐ N ☐ Y - Gall Bladder Problems
- ☐ N ☐ Y - Cancer/Tumors
- ☐ 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 - Diabetes
- ☐ N ☐ Y - Kidney Disease
- ☐ N ☐ Y - Heart Disease
- ☐ N ☐ Y - Arthritis Asthma, Hay Fever
- ☐ N ☐ Y - Stomach Disease Epilepsy, Convulsions
- ☐ N ☐ Y - Hypertension Cancer
- ☐ N ☐ Y - Other (specify): _____

COMMUNICABLE DISEASES

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

- ☐ N ☐ Y - Chicken Pox
- ☐ N ☐ Y - Measles (Rubella)
- ☐ N ☐ Y - Measles (Rubeola)
- ☐ N ☐ Y - Mumps
- ☐ N ☐ Y - Pertussis
- ☐ N ☐ Y - Scarlet Fever
- ☐ N ☐ Y - Tuberculosis
- ☐ N ☐ Y - OTHER: (specify): _____

FEMALES ONLY:

- ☐ N ☐ Y - Irregular Periods
- ☐ N ☐ Y - Severe Cramps
- ☐ N ☐ Y - Excessive Flow
- ☐ N ☐ Y - Are you pregnant?
- ☐ N ☐ Y - Previous pregnancies

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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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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): _____

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

Ears/Nose/Throat: _____

Ophthalmological: _____

Teeth: _____

Neurological: _____

Cardiovascular: _____

Respiratory: _____

Musculoskeletal: _____

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

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 ____

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: