YWAMSHIPS
KONA, HI • ORANGE COUNTY, CA

HEALTH FORM

TO THE APPLICANT: This health form is treated as confidential.

Please choose one: _____Trainee _____ Staff _____Volunteer _____ Team

NAME _____ DATE OF BIRTH_____

ADDRESS_____

EMAIL_____PHONE _____

DO YOU HAVE MEDICAL INSURANCE THAT COVERS YOU IN HAWAII? _____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) _____

IMMUNIZATIONS Please list all basic or last booster, or if you have a copy of records feel free to attach separately.

	YEAR	**YEAR**	YEAR	YEAR	YEAR	YEAR
Diptheria						
Tetanus						
Pertussis						
Polio						
Rubella						
Measels						
Mumps						
Hep A						
Hep B						
Typhoid						

PERSONAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Skin Condition	☐	☐	Heart trouble	☐	☐	Jaundice
☐	☐	Eye trouble	☐	☐	High blood pressure	☐	☐	Hepatitis
☐	☐	Ear 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	☐	☐	Anemia
☐	☐	Mental disorders	☐	☐	Stomach/duodenal ulcer	☐	☐	Venereal disease
☐	☐	Tumor/cancer	☐	☐	Insomnia	☐	☐	Shortness Breath

MENTAL HEALTH & ADDICTIONS
Do you currently or have you previously had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Alcohol Addiction	☐	☐	Drug Addiction	☐	☐	Depression
☐	☐	Self Harm	☐	☐	Bipolar	☐	☐	Eating disorder
☐	☐	Anxiety	☐	☐	Other_____			

SURGERY
Please list any surgeries you have undergone:_____

ALLERGIES
Please list any and all allergies: _____

FEMALES ONLY

YES	NO		YES	NO		YES	NO	
☐	☐	Irregular periods	☐	☐	Severe cramps	☐	☐	Pregnant

COMMUNICABLE DISEASES
Have you ever had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Chicken Pox	☐	☐	Mumps	☐	☐	Tuberculosis
☐	☐	Measles (rubella)	☐	☐	Pertussis	☐	☐	Other_____
☐	☐	Measles (rubeola)	☐	☐	Scarlet fever			

FAMILY HISTORY
Have any of your relatives ever had any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Arthritis	☐	☐	Epilepsy/convulsions
☐	☐	Kidney Disease	☐	☐	Stomach Disease	☐	☐	Cancer
☐	☐	Heart Disease	☐	☐	Hypertension	☐	☐	Asthma/hay fever

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To be filled out and signed by a physician (Trainees & Staff Only:

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

PHYSICIAN'S SIGNATURE_____DATE_____

PHYSICIANS NAME_____ADDRESS_____

PHONE_____EMAIL_____