



Institute for the Nations, Australia
 Youth With A Mission- Byron Bay/ Brisbane
 Application Form

Part Five – Medical and Health Evaluation

To the Applicant:

Step 1	Fill in Part A of this form
Step 2	Afer you have filled in Part A of the form you will need to make an appointment for a full medical examination with your own doctor
Step 3	Give the form to your doctor to fill in at the examination and have him/her forward it to the Registrar at YWAM Byron.

Note: All staff and students in YWAM are required to have a full medical. The purpose for this is to have centralized medical details available should any person become sick while away from their personal physician and in YWAM care. All information is confidential to your leaders and this form is kept separately from your academic records.

PART A- Personal Details and Medical History		
You are applying for:	DTS / SOFM	Start Date: (Month/Year)
Your Name	Mr. Miss. Mrs. <input type="text"/> First <input type="text"/> Family/Sir Name	
Email Address	<input type="text"/>	
Phone	Home: <input type="text"/>	Work: <input type="text"/>

Please answer all questions. Comment on all positive answer at the end of this form or on a separate sheet.

Have you ever had any of the following?

	No	Yes		No	Yes		No	Yes
Skin Conditions	<input type="radio"/>	<input type="radio"/>	Shortness of Breath	<input type="radio"/>	<input type="radio"/>	Stomach/Duodenal Ulcer	<input type="radio"/>	<input type="radio"/>
Eye Trouble	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>	Gall Bladder Problems	<input type="radio"/>	<input type="radio"/>
Ear Trouble	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>
Head Injury	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Intestinal Troubles	<input type="radio"/>	<input type="radio"/>
Recurrent headaches	<input type="radio"/>	<input type="radio"/>	Low Blood pressure	<input type="radio"/>	<input type="radio"/>	Recurrent diarrhea	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	Heart Trouble	<input type="radio"/>	<input type="radio"/>	Chronic constipation	<input type="radio"/>	<input type="radio"/>
Fainting spells	<input type="radio"/>	<input type="radio"/>	Rheumatism/Arthritis	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Weakness	<input type="radio"/>	<input type="radio"/>	Back Problems	<input type="radio"/>	<input type="radio"/>	Kidney Disease	<input type="radio"/>	<input type="radio"/>
Paralysis	<input type="radio"/>	<input type="radio"/>	Dislocation of joints	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Insomnia	<input type="radio"/>	<input type="radio"/>	Broken Bones	<input type="radio"/>	<input type="radio"/>	Venereal Disease	<input type="radio"/>	<input type="radio"/>
Mental/nervous disorder	<input type="radio"/>	<input type="radio"/>	Anorexia/Bulimia	<input type="radio"/>	<input type="radio"/>	Tumor/Cancer	<input type="radio"/>	<input type="radio"/>

Have you ever had any of the following?

	No	Yes		No	Yes		No	Yes
<u>Allergy</u>			<u>Surgery</u>			<u>Females Only</u>		
Penicillin	<input type="radio"/>	<input type="radio"/>	Appendectomy	<input type="radio"/>	<input type="radio"/>	Irregular Periods	<input type="radio"/>	<input type="radio"/>
Sulphonamides	<input type="radio"/>	<input type="radio"/>	Tonsillectomy	<input type="radio"/>	<input type="radio"/>	Severe Cramps	<input type="radio"/>	<input type="radio"/>
Serum	<input type="radio"/>	<input type="radio"/>	Hernia Repair	<input type="radio"/>	<input type="radio"/>	Excessive Flow	<input type="radio"/>	<input type="radio"/>
Foods (specify)	<input type="radio"/>	<input type="radio"/>	Other (specify):	<input type="radio"/>	<input type="radio"/>	Are you pregnant?	<input type="radio"/>	<input type="radio"/>
Other (specify)	<input type="radio"/>	<input type="radio"/>						

Do you have any special dietary needs?

Youth With A Mission- Byron Bay/ Brisbane
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 YWAM Byron Bay (CRICOS # 02157G)
 in partnership with Institute for the Nations – Australia (RTO # 0449)
 Youth With A Mission Canberra Inc t/a Institute for the Nations. ABN: 40 345 561 378.



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Are you presently under a doctor's care for any condition?	No <input type="radio"/> Yes <input type="radio"/> (specify)
Are you taking any medication at this time?	No <input type="radio"/> Yes <input type="radio"/> (specify)
Do you now or have you ever received compensation for disability from any source?	No <input type="radio"/> Yes <input type="radio"/> (specify)
Please provide details for any POSITIVE answers and give details of any other illnesses you have had.	

Have you ever had any of the following communicable diseases?

- | | | | |
|------------------------------------|---|---|---------------------------------|
| <input type="radio"/> Chicken Pox | <input type="radio"/> Measles (Rubella) | <input type="radio"/> Measles (Rubeola) | <input type="radio"/> Mumps |
| <input type="radio"/> Scarle Fever | <input type="radio"/> Pertussis | <input type="radio"/> Tuberculosis | <input type="radio"/> Hepatitis |
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Other (specify) | | |

FAMILY HISTORY

Have any of your relatives every had any of the following?

	No	Yes	Relationship:
Tuberculosis	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>	
Kidney Disease	<input type="radio"/>	<input type="radio"/>	
Heart Disease	<input type="radio"/>	<input type="radio"/>	
Arthritis	<input type="radio"/>	<input type="radio"/>	
Stomach Disease	<input type="radio"/>	<input type="radio"/>	
Epilepsy, Convulsions	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>	
Mental Illness	<input type="radio"/>	<input type="radio"/>	
Asthma, Hay Fever	<input type="radio"/>	<input type="radio"/>	



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