Part B: Physician's Evaluation

Applicant's Name: _____ Date: _____
(last) (first) (middle initial)

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 a health service. As certain conditions such as Diabetes, Epilepsy, heart disease and obesity may affect acceptance, please ensure that any pertinent information in these areas has been included.

To the applicant:
Please complete the requested information below. Upon acceptance, we recommend you obtain the following immunizations/ injections (before arrival to YWAM Ozarks): Typhoid, Hepatitis A, Hepatitis B, and Tetanus Booster (if you have NOT received one in the last 5 years). These are usually recommended by health agencies (Center for Disease Control, etc.) regardless of where you travel. Due to the varied outreach locations, other immunizations, injections and Malaria medication may be recommended and can be obtained before outreach. If you have ever been vaccinated for Cholera, Typhoid, or Yellow Fever, please check the box below and bring that information with you. 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. Please be prepared financially to cover the cost of additional injections. If you decide NOT to receive the recommended immunizations/injections, you will be asked to sign a waiver stating that you understand the specific immunizations/injections recommended and are choosing not to obtain them. Please check the box below if you are NOT obtaining the recommended immunizations/injections.

☐ I have been vaccinated for the following:
☐ Cholera ☐ Typhoid ☐ Yellow Fever

☐ I am choosing NOT to receive the recommended immunizations/injections.

Childhood Record of Immunizations: Basic **Adult Immunizations: Booster**

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

Tuberculosis Control
Either a skin test or chest x-ray result is required within 6 months of your application. If you apply more than 6 months in advance and are accepted, another test is required and we need the result before you arrive.

	Date	Result	Examination Facility
Skin Test*			
Chest X-ray			

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

Date of last DT (Diphtheria/Tetanus) booster: Month _____ Day _____ Year _____
(Must be within the last 5 years.)

Height: _____ Weight: _____ Overweight: _____

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)

E.N.T. _____

Ophthalmological _____

Teeth _____

Neurological _____

Cardiovascular _____

Respiratory _____

Musculoskeletal _____

Endocrine _____

Lymphatic _____

Dermatological _____

Hernial Orifices _____

Urological _____

Psychiatric _____

Recommendations for follow-up tests/treatment: _____

_____

_____

Additional Comments: _____

_____

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

Physician's Recommendation

(check one)

- ☐ Acceptable without limitations.
- ☐ Acceptable with limitations (specify) _____
- ☐ Should remain in areas where adequate medical care is provided (specify) _____

  _____
- ☐ Not acceptable.

Physician's Name (print): _____

Address: _____

Phone: _____ Date: _____

Physician's Signature: _____

Please complete and email this form to DBS@ywamozarks.org. Thank you very much!