Discipleship Training School Application

Confidential Health Form

Full Name ______________________________________ Gender _________

Date of Birth __________ School Applying For ____________ Beginning Date ________

Height ___________ Weight ______________

Personal History: Please answer all questions. Have you ever had the following conditions or procedures? Explain any "Yes" answers in the space provided. Attach

O Skin Condition ____________________

O Eye Trouble ____________________

O Ear Trouble ____________________

O Head Injury ____________________

O Epilepsy ____________________

O Fainting Spells ____________________

O Mental Nerovous Disorder __________

O Weakness ____________________

O Paralysis ____________________

O Insomnia ____________________

O Shortness of Breath ______________

O Hay Fever/Asthma ______________

O Heart Trouble ____________________

O High Blood Pressure ______________

O Low Blood Pressure ______________

O Rheumatism/Arthritis ______________

O Back Problems ____________________

O Dislocation of Joints ______________

O Broken Bones ____________________

O Eating Disorder ____________________

O Stomach/Duodenal Ulcer __________

O Gall Bladder Problems ____________

O Intestinal Troubles ______________

O Recurrent Diarrhea ______________

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Confidential Health Forms (continued)

O Kidney Disease ____________________
____

O Anemia ____________________________
____

O Venereal Disease __________________
____

O Tumor/Cancer ______________________
____

O Jaundice __________________________
____

O Hepatitis _________________________
____

Surgery

O Appendectomy ______________________
____

O Hernia ____________________________
____

O Tonsillectomy _____________________
____

O Other _____________________________
____

Allergies

O Food ______________________________
____

O Penicillin ________________________
____

O Sulfonamides ______________________
____

O Serum _____________________________
____

O Other _____________________________
____

Females Only

O Irregular Periods _________________
____

O Severe Cramping ___________________
____

O Excessive Flow ____________________
____

O Current Pregnancy _________________
____

O Previous Pregnancy ________________
____

Explain any other health issues, medical conditions, or physical handicaps: __________
____

Are you currently under a doctor's care for any condition? __________________________

Are you taking medication at this time? ____
____

Do you have a history of emotional instability or psychiatric treatment? _____________
____

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Confidential Health Forms (continued)

Height _______ ft. _____ in. Weight ___________(in pounds)

Blood Type_________

Have you had any of the following?

O Chicken Pox O Measles/Rubella O Tuberculosis O Pertussis
O Scarlet Fever O Mumps O Other ______________________

Have you or any of your relatives ever had any of the following communicable diseases?

O Tuberculosis ______________________
____
O Hay Fever ________________________
____
O Arthritis __________________________
____
O Heart Disease _____________________
____
O Diabetes _________________________
____
O Convulsions ______________________
____
O Stomach Disease __________________
____
O Epilepsy _________________________
____
O Kidney Disease ___________________
____
O Hypertension _____________________
____
O Asthma ___________________________
____
O Cancer ___________________________
____

Can you walk 3-4 miles per day? Yes No

Insurance

Health Insurance Company Name ____
Insurance policy number ____

Emergency Contact

Name(s) ____________________________________ Relationship __________________
Phone ( )____________ O Home O Cell O Work
Additional ( )____________ O Home O Cell O Work