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.

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