YWAM Slovakia Confidential Health Form

Please fill out this form, have it signed by your physician, and return it to us by post or email.

YWAM Slovakia
Pod Sokolom 1
97661 Lucatin
Slovakia

Email : dts@ywam.sk
Phone: (+421) 911 381 819

Applicant's name:

Blood type (if known):

☐ Health History

How would you rate your overall health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any illness or condition (past or present) we should be aware of? ☐ Yes ☐ No

Are you presently under a doctor's care for an illness or condition? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No

Do you have any allergies that we should be aware of? ☐ Yes ☐ No

Do you have any physical impairments, handicaps, or health conditions which require special accommodation: ☐ Yes ☐ No

Do you have any special dietary requirements? ☐ Yes ☐ No

If you answered yes to any of the previous questions please provide details below:

Have you been in psychiatric/psychological care? If so, why?

☐ Immunizations

Please write the date of the last immunization for each of the following:

Hepatitis A (please list last 2)

Hepatitis B (please list last 3)

Typhoid

Tetanus/Diphtheria

Measles/Mumps/Rubella (MMR)

Polio

Because the outreaches take place in countries where you are at risk of contracting these diseases, we strongly recommend these vaccinations be up to date. When you go in for your shots, ask your doctor to record them in a traveler's immunization record. Please send us a copy, and bring the original with you. **If you refuse vaccinations for personal reasons, both you and your physician must sign below indicating that you have been informed of the risks involved.**

Applicant's signature:

Physician's signature:

☐ To the Physician:

Please review the information the applicant has given in the previous sections.

In your professional opinion, is the applicant physically and emotionally able to undertake 6 months of extended cross-cultural travel in developing nations?

☐ Yes ☐ Yes with limitations ☐ No

If you marked 'Yes with limitations' or 'No' please elaborate:

Please use the space below to include any other information you think we should know:

Physician's name and address or practice stamp:

Physician's signature (required):