PHYSICIAN'S EVALUATION

Youth With A Mission - Montego Bay
Box 198, Reading P.O.
St. James, James
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Dear Doctor, _____(Applicants Name) has applied for service with Youth with a Mission. Youth with a Mission sends volunteers into remote locations around the world where medical treatment and services are limited, at best. Volunteers are sometimes exposed to uncommon risk to health, safety and welfare.

Applicants will be subjected to physical and emotional stresses that they may have never encountered before. They may be living in close quarters with up to 4 roommates, with the probability of temperatures in excess of 30C(86F) for long periods of time. The usual workday is eight hours long and is often strenuous both physically and emotionally. Please REVIEW the applicant's "Personal Health History" and perform a thorough physical examination. Perform any diagnostic tests you feel are appropriate, and please COMPLETE this form. Please COMMENT on any concerns you may have as they relate to the applicant's ability to tolerate physical and emotional conditions in developing nations.

How long has the applicant attended your office? years,_____months_____, just today_____

Height (in cm.) _____ Weight (in kilos.) _____ Age_____

Blood Pressure_____ Pulse_____ Blood Type O A B AB + - (Circle One)

Visual Acuity: (no lenses) R:20/ L:20/ (with) R:20/ L:20/ Color Perception: Normal: Yes No

Hearing: R: Normal – Yes No L: Normal – Yes No

Is the applicant currently on any medication: ☐ Yes ☐ No
Has the applicant taken any medication for longer than one month in the past 5 years ☐ yes ☐ no (prescription or non-prescription)

(Please arrange to bring all necessary long-term medication with you, as supplies may not be available. Except for very new medicines, most are available in Jamaica.)

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? IF YES, PLEASE DESCRIBE FULLY.

___ Dermatological
___ Head/Neck
___ Ear/Nose/Throat
___ Ophthalmologic
___ Mouth/Teeth
___ Lymphatic
___ Respiratory
___ Cardiovascular
___ G.I.
___ Urological
___ Genito-Reproductive
___ Musculoskeletal
___Neurological
___ Psychiatric
___ Endocrine

Recommendations for follow-up test/treatment.

PHYSICIAN'S RECOMMENDATION: (Please check one)
___Accept
___Accept with limitations: (please comment on back)
___No Do Not accept (Comment on back)

Physician's Signature:_____ Date:_____
Printed Name:_____
Phone:_____ Fax:_____

CONFIDENTIAL PERSONAL HEALTH HISTORY

NAME: _____

PLEASE ANSWER ALL QUESTIONS. BRIEFLY COMMENT ON ALL "YES" ANSWERS.

Have you ever had any of the following?

_____Skin conditions
_____High blood pressure
_____Eye trouble
_____Low blood pressure
_____Ear trouble
_____Kidney disease
_____Head injury
_____Weakness
_____Anemia
_____Paralysis
_____Rheumatism/Arthritis
_____Insomnia
_____Tumor/Cancer
_____Shortness of breath
_____Back problems
_____Hay fever

_____Gall bladder problems
_____Recurrent headache
_____Intestinal problems
_____Fainting spells
_____Recurrent diarrhea
_____Nervous disorders
_____Heart trouble
_____Stomach/Duodenal ulcer
_____Jaundice
_____Epilepsy
_____Hepatitis
_____Dislocation of joints
_____Diabetes
_____Eating disorder
_____Broken bones
_____HIV

_____Venereal disease
_____Allergies (Specify)
_____Medications (Specify)

_____Surgery (Specify)

FEMALES ONLY:

_____Irregular period's
_____Severe cramps
_____Excessive flow

_____Previous pregnancies
_____Are you pregnant

FAMILY HISTORY: Have any members of your immediate family ever had any of the following? If yes, give relationship.

_____Tuberculosis Relationship_____
_____Diabetes Relationship_____
_____Arthritis Relationship_____
_____Asthma/Hay Fever Relationship_____
_____Kidney Disease Relationship_____
_____Stomach Disease Relationship_____
_____Epilepsy/Convulsions Relationship_____

Other Health Issues: Explain: (include reason, results & dates)

_____Do you wear glasses/contact lenses?

_____Have you had any medical tests done in the past 5 years (x-rays, blood test, scan, EKG, brain scan, ultrasound)?

_____Have you been off work or worked partially restricted for more than 14 days for medical reasons?

_____Do you feel you have any disease or condition that would limit your normal daily living condition?

Please bring original documents to the school with you.