Discipleship Training School Application Confidential Health Form

TO THE STUDENT: This information is treated confidentially and separate from your academic records. Answer all questions in ink or by typing IN ENGLISH.

1. Your Name

2. Personal History

Please answer all of the questions and comment on all applicable questions in the space provided.

Have you ever had, or do you have, any of the following?

Eye Trouble	Yes	No
Ear Trouble	Yes	No
Head Injury	Yes	No
Recurrent Headache	Yes	No
Epilepsy	Yes	No
Fainting Spells	Yes	No
Weakness	Yes	No
Paralysis	Yes	No
Insomnia	Yes	No
Broken bones	Yes	No
Dislocation of joints	Yes	No
HIV positive	Yes	No
Hepatitis A,B or C	Yes	No (specify)
Stomach/Duodenal Ulcer	Yes	No
Jaundice	Yes	No
Intestinal trouble	Yes	No
Recurrent Diarrhea	Yes	No
Back problems	Yes	No
Hay fever/Asthma	Yes	No
Skin Conditions	Yes	No (specify)

Shortness of breath	Yes	No	
Anemia	Yes	No	
Heart trouble	Yes	No	
High or low blood	Yes	No	pressure
Rheumatism/Arthritis	Yes	No	
Chronic constipation	Yes	No	
Diabetes	Yes	No	
Kidney disease	Yes	No	
Venereal disease	Yes	No	
Tumor/Cancer	Yes	No	

If you answered "Yes" to any of the above questions please describe in the field below:

3. ALLERGIC REACTIONS TO

Sulphonamides	Yes	No	
Penicillin	Yes	No	
Foods/Other	Yes	No	(specify)

4. SURGERY

Appendectomy	Yes	No
Hernia repair	Yes	No
Tonsillectomy	Yes	No
Other (specify)	Yes	No

5. FEMALES ONLY

Irregular periods	Yes	No
Severe cramps	Yes	No
Excessive flow	Yes	No
Are you pregnant	Yes	No

If you answered "Yes" to any of the above questions please describe in the field below:

6. Mental/Nervous Disorders

Have you ever struggled with a mental or nervous disorder under any of the following categories:

Anxiety	Yes	No
Depression	Yes	No
Bipolar	Yes	No
Eating	Yes	No
Developmental	Yes	No
Personality	Yes	No
Psychotic	Yes	No
Sleep	Yes	No
Dissociative	Yes	No
Behavioural	Yes	No
Addiction	Yes	No
Suicidal Thoughts	Yes	No

If yes, please give details including specific type of disorder, treatment and ongoing treatment/problems:

7. Have you ever had professional counselling?

Yes / No

If yes, please give type of counselling and duration.

8. Medical Treatment

Please specify any condition that is currently under treatment by a doctor of health care professional:

9. Compensation

Do you or have you ever received any compensation for disability, from any source?

10. Communicable Diseases

Have you ever had any of the following:

Chickenpox	Yes	No
Measles (Rubella)	Yes	No
Measles (Rubeola)	Yes	No
Mumps	Yes	No
Pertussis	Yes	No
Scarlet Fever	Yes	No
Tuberculosis	Yes	No
Other (specify)	Yes	No

If Other, Please Specify which communicable disease/s you had or currently have that is not mentioned:

11. Family History

Have any of your relatives ever had any of the following:

Arthritis	Yes / No	Relationship to you
Asthma, Hay Fever	Yes / No	Relationship to you
Cancer	Yes / No	Relationship to you
Epilepsy/Convulsions	Yes / No	Relationship to you
Heart Disease	Yes / No	Relationship to you
HIV/AIDS	Yes / No	Relationship to you
Kidney Disease	Yes / No	Relationship to you
Mental illness	Yes / No	Relationship to you
Stomach Disease (Please specify)	Yes / No	Relationship to you

12. Immunizations

In order to join this school you will need to have the following Immunizations

-Hepatitis A

-Hepatitis B

-Tetanus

-Diphtheria

-Polio

-Typhoid

Which of the above do you currently have?

13. Declaration

I declare that all the information contained herein is true, correct and complete to the best of my knowledge.

Full Name

Applicant's Signature

Date day / month / year

Parent / Guardian If applicant is under 18 years of age than the signature of parent / guardian is also required.

Full Name

Signature

Date day / month / year

Relationship to applicant