

REACH MINISTRIES INTERNATIONAL HEALTH HISTORY FORM

(Note: This form may or may not have to be filled out by a physician depending on the trip you are taking. Please call our office to be sure.)

Applicant's Name: _____
Short-Term Missions Trip To: _____ Dates: _____

To be completed by the applicant and/or physician. Answer YES or NO to the following conditions whether you have them or not. If you answered YES, briefly explain under "REMARKS".

Sinus Condition	_____	Shortness of Breath	_____
Ear Problems	_____	Skin Infection	_____
Lung Problems	_____	Hearing Difficulty	_____
Heart Trouble	_____	Bad Eyesight	_____
High Blood Pressure	_____	Do you wear contacts?	_____
Fainting or Dizzy Spells	_____	Any medical care in the past year?	_____
Seizures	_____	Any surgery in the past year?	_____

Have you been exposed to any known infectious disease in the past three weeks? YES _____ NO _____
Hepatitis? _____ Other _____
Do you have any disorder preventing strenuous activity? _____
Are you currently taking any prescribed medication? _____
Do you have a negative reaction to any drug or medication of any type? _____

REMARKS:

List any allergies:

Give the date of inoculation or vaccination against the following: Tetanus _____ Small Pox _____
Measles _____ Typhoid _____ Diphtheria _____ Polio _____

Name and address of person to notify in case of an emergency _____

Phone number (including area code): _____

I know of no reason physically to be restricted from participation in this ministry:

Signature: _____ Date: _____

PHYSICAL EXAMINATION: Physician, please note. This activity is mostly conducted outdoors under very warm conditions. Manual labor and lifting will be involved, and unsanitary conditions may exist.

Applicant's Name: _____ Examination Date: _____ DOB: _____
Height: _____ Weight: _____ Occupation: _____

Briefly:
Heart _____ Lungs _____ Throat _____ Ears _____ Eyes _____
Skin Condition _____ Hernia _____ Blood Pressure _____

In your opinion, is the applicant physically capable of travel, physical labor, and mission work under unfavorable conditions? _____ YES _____ NO

Physician's Name and Address: _____
Physician's Signature: _____ Phone: (____) _____
Health Insurance Company: _____ Policy/Group No.: _____ Deductible: _____