

These Resource Ministry Medical Form

General Information

Name (first) _____ (middle) _____ (last) _____

Permanent Address _____ Home Phone () _____ - _____

City _____ State _____ Zip _____ Work Phone () _____ - _____

2. School Name/Address _____

City _____ State _____ Zip _____ School Phone () _____ - _____

3. ___Male ___Female Birth date ___/___/___ Age _____ Height _____ Weight _____

4. Social Security Number _____ - _____ - _____ 5. Passport #: _____

If not a USA citizen, please give your nationality, visa classification and number: _____

6. Marital Status ___Single ___Married ___Separated ___Divorced ___Remarried

Wife: _____ Children/Ages: _____

IN CASE OF EMERGENCY:

7. Father/Guardian's name/address _____ Home Phone () _____ - _____

Employed by: _____ Work Phone () _____ - _____

Mother/Guardian's name/address _____ Home Phone () _____ - _____

Employed by: _____ Work Phone () _____ - _____

If parents are divorced or separated, who has legal custody? ___Father ___Mother ___Joint ___Other _____

Other nearest relative at home Name _____ Home Phone () _____ - _____

Relationship: _____

Name of Personal/Family Physician: _____ Work Phone () _____ - _____

Address: _____

Personal Insurance

1. Health Insurance Co. _____ Policy # _____

2. Individual or Group Coverage? _____ Policy Holder Name: _____

Personal Health

All of the following questions must be answered. Any misrepresentation will void your acceptance.

A. Family Medical History

1. Do your grandparents, parents or siblings have:

Diabetes Yes ___ No ___ Hypertension Yes ___ No ___ Heart disease Yes ___ No ___

Depression Yes ___ No ___ Mental Illness Yes ___ No ___

2. If you answered yes to any of the above, explain who and give a brief explanation: _____

B. Personal Medical History

1. Rate your general health: ___Excellent ___Good ___Fair ___Poor.

2. What was the date and who was the attending physician of your last physical exam? _____

3. Have you ever had ()Diabetes ()Seizures ()Fainting spells ()Eating disorders ()Psychiatric care
()Respiratory problems ()Phobias: Explain: _____

4. Have you ever received treatment or counseling for alcohol or chemical abuse? Yes ___ No ___

If yes, please specify when and where: _____

5. List all surgical operations or hospitalizations you have undergone: (date, reason for operation or illness, name and address of hospital, name of physician, any remaining effects) If you have been hospitalized more than two times, please give an explanation: _____

6. Have you ever been treated by a doctor for any of the following? (Every item must be checked. If you check "YES" to any of the following, you are required to have your physician see and sign this completed form. Completely fill out the Doctor's Release. If you do not your acceptance will become void.)

YES NO

- Asthma or chronic wheezing
- Emphysema or other lung and/or respiratory problems
- Chronic persistent cough or shortness of breath
- Tuberculosis
- Any skin disorder or disease other than acne
- Chronic or recurrent ear or eye problems
- Impairment of hearing or vision. Meniere's disease, cataracts or glaucoma
- Persistent recurring indigestions, stomach or duodenal ulcers
- Gall bladder stones or colic
- Jaundice cirrhosis or other liver problems
- Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding.
- Any test results indicating exposure to the AIDS virus.
- Albumin, blood or pus in the urine, painful or frequent urination: or kidney problems
- Diabetes or Hypoglycemia (low blood sugar)
- Serious bodily injury
- Mental health counseling or psychiatric treatment
- Rheumatism, gout, arthritis or other forms of swollen painful joints
- Chronic back pain, back injury or surgery, sciatica, scoliosis or other bone or joint disorder
- Cysts, tumors or growths of any kind, hernia or rupture
- Cancer (Type: _____)
- Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
- High blood pressure heart murmurs or other cardiac problems
- Vein or circulatory trouble
- Severe migraine headaches
- Goiter, thyroid ailment, high or low metabolism
- Anemia or other blood disorder
- Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders, or venereal disease
- Parkinson's disease
- Severe knee injury or problems
- Severe allergic reaction to either food, medicines, bee stings or any other insect bite or sting
- Any other diseases, deformity, or disability not listed above

C. Current Physician's Care or Medications

1. Are you currently taking any prescribed medication? Yes ____ No ____

If yes, please specify the medication and the dosage _____

2. Are you currently regularly using any non-prescription drugs (antihistamines, sleeping aids, etc.)? Yes ____ No ____

If yes, please specify: _____

3. Are you currently under a physician's care for any illness? Yes ____ No ____

If yes, please explain: _____

I/WE as the parents of _____ hereby authorize the staff of THEEE RESOURCE MINISTRY, INC. to consent to and authorize for me/us the administration of any and all reasonable first-aid operations, hospitalizations, which in either of their opinions become necessary to save or maintain the life, health, or well-being of my/our child. I/WE agree to and shall hold harmless from any liability the sponsor for any such determination and authorization given by either or all of them in good after full disclosure by trained medical personnel. In the event of the inability or refusal of the sponsors to give any such consent or authorization. I/We hereby authorize any paramedic, medical technician, doctor or nurse to take any reasonable action and to administer any reasonable medication which in their professional opinion is necessary to save or maintain the life, health, or well-being of my/our child.

Applicant's Signature

Parent or Guardian's Signature (for a minor)

DOCTOR'S RELEASE FORM (if necessary)

I have reviewed this patient's medical information and checklist form and medical history and I have performed a physical exam. I find him/her to be in suitable condition for international travel, for participation in high-intensity activities, (i.e. hiking several miles) and conditions in a third world country.

Physician's Signature: _____

Date: _____

Doctor's Name: _____

Doctor's Phone () _____ - _____

Address: _____