Medical Reference

APPLICANT'S NAME _____

- Please complete **all** sections of this reference.
- It will help us if you type your answers or print carefully in black/blue ink.
- If you need more space to answer a question, please use a separate piece of paper.
- Husbands and wives must supply separate medical references.
- We reserve the right to ask you to have a medical reference completed by a medical doctor, depending on the advice of our Medical Officer.

APPLICANT'S RELEASE OF MEDICAL INFORMATION

I _____(applicant's name), give permission for medical information to be reviewed by a registered nurse or medical doctor (or suitably qualified allied health professional) for purposes of assessing my suitability for service with Youth With A Mission.

I give permission for the release of relevant medical information to the Youth With A Mission medical officer in consultation, if necessary, with the personnel manager or team leader only.

Signed _____ Date dd/mm/yy) _____

PLEASE RETURN THIS FORM TO:
THE REGISTRAR, YWAM CARLISLE, THE OLD VICARAGE, WEST WALLS, CARLISLE, CA3 8UF
Tel: +44 1228 319058
Email: carlisledts@gmail.com

1

Applicant's name (Title/Surname/First Name) _____

Date of Birth _____

NHS No. (British)_____

Current Address _____

_____

_____Post/Zip Code _____

Position being applied for_____

Anticipated start date (dd/mm/yy) _____

2 GENERAL HEALTH

Are you able to walk up to six miles (10 kilometres) in one day? ▫ Yes ▫ No

If this is a problem, please explain: _____

_____

Are you able to carry out reasonably strenuous physical work? ▫ Yes ▫ No

If no, please explain: _____

_____

Are you presently in good health? ▫ Yes ▫ No

If no, please give brief details:_____

_____

Do you currently have any infectious diseases? ▫ Yes ▫ No

If yes, please give brief details:_____

_____

Please list any allergies or dietary restrictions that you have _____

_____

3 MEDICAL HISTORY

Please answer the following questions as fully as possible:

List all the SERIOUS ILLNESSES and OPERATIONS you have had in the past. (This means any illness requiring hospital admission, treatment from your doctor for an illness lasting more than

one month, or any illness that may have an affect on your health both now and in the future.) Please also state the outcome and whether there are any residual problems.

Illness/Operation	**Date**	**Outcome**

List any SERIOUS MENTAL or PHYSICAL ILLNESS in your IMMEDIATE FAMILY

Illness	Family Member

Describe any CURRENT MEDICAL PROBLEMS for which you are receiving treatment, or which may affect your health:

_____

_____

_____

_____

List any MEDICATIONS which you take, either on a regular basis, or only when needed and for what illness:

_____

_____

_____

_____

What is your height?	Feet	Inches	(or	metres)
What is your weight	Stone	Lbs	(or	kilogrammes)

Describe any current mental health problems for which you are receiving treatment or have received treatment in the past (eg. anxiety, depression, panic attacks, eating disorders, self-harming, bi polar disorder or other psychiatric disorders). Please give **dates of treatment** under the care of a physician or psychiatrist/psychologist and any medications you were prescribed.

_____

_____

_____

_____

_____

Is there any other information that will be helpful for us to know as we consider your application?

_____

_____

_____

_____

4 INOCULATIONS

Due to our close living conditions, we require all staff and trainees to be up to date with their inoculations including:

Did you complete your childhood vaccines? ▫ Yes ▫ No

- Rubella (single dose) ▫ Yes ▫ No Date of vaccination _____
- Tetanus ▫ Yes ▫ No Date of vaccination_____

(we require Tetanus booster within last 10 years, especially if travelling to developing nations)

- Please send us the results of a recent Tuberculosis test.

If these are not available in your country, we will require you to have them within one month of arrival, at your own expense. (This form is not complete until this section has been answered)

5 FOR WOMEN ONLY

Do you have any gynecological problems that still affect you? (eg. Problems with past pregnancies or menstrual periods that affect your daily functioning?) If yes, please explain.

_____

_____

I confirm that this is a true reflection of my medical history and that failure to give any relevant information may lead to my involvement with Youth With a Mission being terminated.

Signed _____ Date: _____