## Youth With A Mission Oxford, New Zealand YWAM Oxford Confidential Health Form (DTS and



## **BLS Students)**

Please fill out this form, have it signed by your physician, and return it to us at: YWAM Oxford

Fax: +64 3 312 4955

PO Box 47

Oxford 7443 NE	W ZEALAND	E-mail: registrar@ywamoxford.org		
Applicant's	name:			
Blood type (	if known):			
Health History				
How would you	rate your overall he	ealth?		
Excellent	Good 🗌	Fair 🗌	Poor	
Do you have any	illness or condition (	past or present) we should be awar	re of? Yes 🗌	No 🗌
Are you presently	under a doctor's car	Yes 🗌	No 🗌	
Are you currently	taking any medication	Yes 🗌	No 🗌	
Do you have any	allergies that we sho	Yes 🗌	No 🗌	
Do you have any physical impairments, handicaps, or health conditions which require special accommodation:			Yes 🗌	No 🗌
Do you have any special dietary requirements?			Yes 🗌	No 🗌
If you answered	yes to any of the a	bove questions please provide	details below:	

## Youth With A Mission Oxford, New Zealand



Immunizations					
Please write the date of the last immunization for each of the following:					
Hepatitis A (last 2)					
Hepatitis B (last 3)					
Typhoid					
Tetanus/Diphtheria					
Measles/Mumps/Rubella					
Polio					
Because the outreaches take place in countries where you are at risk of contracting the diseases, we strongly recommend these vaccinations be up to date. When you go in for yo shots, ask your doctor to record them in a traveler's immunization record. Please send us copy, and bring the original with you. If you refuse vaccinations for personal reasons, bo you and your physician must sign below indicating that you have been informed of the risks involved.					
Applicant's signature: Physician's signature:					
To the Physician:					
Please review the information the applicant has given in the above sections.					
In your professional opinion, is the applicant physically and emotionally able to undertake					
months of extended cross-cultural travel in developing nations?					
es 🗌 Yes with limitations 🗌 No 🗌					
ou marked 'Yes with limitations' or 'No' please elaborate:					
Please use the space below to include any other information you think we should know:					
Physician's name and address or practice stamp:					
Physician's signature (required):					

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