

Team Ministry Health History for Youth Encounter

Full Legal Name of Participant: _____

Date of birth ____/____/____

Team: _____ Destination: _____ Dates of service: _____

Please fill this out completely and sign page 3 guaranteeing the answers are true.

Are you generally a healthy person? Yes No

Explain: _____

Have you been under a physician's *regular* care in the past year? Yes No

Explain: _____

Name _____ Phone (____) _____
Attending Physician

Address _____
Street City State Zip

Do you take prescribed medication regularly? Yes No

Name of medication : _____

Condition for which prescribed: _____ Dosage _____

Name of medication: _____

Condition for which prescribed: _____ Dosage _____

Have you been hospitalized within the last year? Yes No

If "Yes", for what reason? _____

Name _____ Phone (____) _____
Attending Physician

Address _____
Street City State Zip

Family or General Practice Medical Clinic and/or Physician

Name _____ Phone (____) _____
Clinic and/or Physician

Address _____
Street City State Zip

In case of an emergency, notify:

Name _____

Relationship _____

Address _____

City/State/Zip _____

Home Phone (____) _____

Work Phone (____) _____

If not available, notify:

Name _____

Relationship _____

Address _____

City/State/Zip _____

Home Phone (____) _____

Work Phone (____) _____

Have you had any problems with:

- **Arthritis, carpal tunnel, gout, back problems, sciatica, muscle problems, bones, nerves, joints; or chiropractic or physical therapist consultation?** Yes No

Explain: _____

- **Diabetes, thyroid or other glandular disorder?** Yes No

Explain: _____

- **dizziness, fainting, convulsions or epilepsy?** Yes No

Explain: _____

- **shortness of breath, asthma or coughing up blood?** Yes No

Explain: _____

- **chest pain, high blood pressure, heart murmur or heart disorder?** Yes No

Explain: _____

- **ulcers, colitis, chronic diarrhea, intestinal bleeding or other disorder of stomach or intestine, liver, gallbladder?** Yes No

Explain: _____

- **cancer, tumor, cyst or disorder lymph glands?** Yes No

Explain: _____

- **migraines, severe or chronic headaches?** Yes No

Explain: _____

- **sleeplessness?** Yes No

Explain: _____

- **addiction or substance abuse?** Yes No

Explain: _____

- **physical, verbal or sexual abuse?** Yes No

Explain: _____

- **clinical depression, emotional or behavioral disorder?** Yes No

Explain: _____

- **eating disorder?** Yes No

Explain: _____

- **Hepatitis A, B or C, HIV, or any other blood disorder?** Yes No

Explain: _____

Family Structure - Parents: What's your relationship like? _____

Siblings: Do you have any siblings? If so, how many? Explain your relationships.

Other family information that would be helpful: _____

Immunization history: Please note the immunization dates or most recent booster dates. If dates are unknown, please indicate if immunization has been received. The following immunizations need to be received before coming to training. (You may need other immunizations for traveling internationally.)

Date		Date			
__/__/__	DPT Series-usually given as an infant	__/__/__	MMR (Measles/Mumps/Rubella) - Infant		
__/__/__	Tetanus (most recent - every 7-10 years)	__/__/__	MMR (Measles/Mumps/Rubella)- Adult		
__/__/__	1 st Hepatitis A shot	__/__/__	2 nd Hepatitis A		
__/__/__	1 st Hepatitis B shot	__/__/__	2 nd Hepatitis B	__/__/__	3 rd Hepatitis B

Blood Type: A+ A- AB+ AB- B+ B- O+ O-

Allergy Information: Please note any allergies.
Do you have any food allergies? Please list.

Are you allergic to any medications? Please list and explain effects below. (Please wear a Medic Alert Bracelet with this information.)

Do you have dietary restrictions or guideline? Please explain.

Are you allergic to any household pets? Please list.

Do you have any other allergies that we should be aware of? If so, please list and explain below.

Please Read and Sign

I hereby certify that the answers included are complete and true to the best of my knowledge. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution, or person who has attended me, to furnish Youth Encounter or its representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital and medical records, in order to obtain medical care and information on pre-existing conditions. I also authorize Youth Encounter or its representatives to discuss any health concerns with parents/family and medical professionals, if needed. This release shall be valid from the date signed until August of the following year. I agree that a photographic copy of this authorization shall be as valid as the original.

Signature in ink Date _____

Participant's name _____

I voluntarily waive any claim against Youth Encounter, church contacts, or Youth Encounter personnel for any mishap or any and all accidents, injuries, and illnesses that may arise in connection with Team Ministry activities. In addition, if Youth Encounter staff has to secure medical treatment for the above named person, they may do so. If my emergency contacts cannot be reached at the given numbers, I hereby authorize Youth Encounter staff to sign for necessary emergency and/or general medical treatment. This includes x-rays, injections, and surgery for the above named person during the time they participate in Team Ministry. I understand that in a case of an emergency, all attempts will be made to contact my noted emergency contact prior to medical treatment.

My signature verifies that all information given on this form is correct to the best of my knowledge.

Signature in ink Date _____

Physician's Statement

Name: _____

Community Based Team National Traveling Team International Traveling Team

NOTE TO PHYSICIAN: Team Ministry activities may include:

- Daily road travel for approximately one year. Daily van rides average about 3 hours each day, trips may sometimes be up to 12 hours. For International Team volunteers, some trips may be more than 24 hours by bus or train.
- Daily carrying of luggage, sound equipment, supplies, etc.
- Daily performances of one to two hours. International Team may include five or more performances some days.
- Air travel.
- Less than adequate rest at times.
- Playing games and leading activities.
- Exposure to many different foods, often unusual in comparison to one's normal diet.
- Considerable amount of stress from intense community living.
- For International Team volunteers, exposure to tropical diseases and climate, and often considerable distance from major hospital.

The above individual has been examined by me and I find him/her: (please check)

- Qualified for team ministry activities with no restrictions.
- Qualified for team ministry activities but has a minor condition(s) that will not interfere with employment as far as I can judge worker/job match.
- Qualified for team ministry activities but will need on-going medical follow up for a physical or mental condition.
- Qualified for team ministry with the following recommended restrictions:

- Recommendation will be withheld at this time pending further treatment, evaluation or information.
- This individual is, in my estimation, not qualified for the Team ministry activities as suggested. Reasons for this have been fully discussed with the individual concerned.

COMMENTS:

Signed _____ Please Print Name _____

Date _____ Clinic Address _____

Phone (_____) _____ City, State, Zip _____