Mission College of Evangelism

Medical Information Form

Please fill out pages 1 - 3 of the Medical Information Form completely. You will then need to make arrangements to have a physical performed by your physician. Take the pages you have completed, pages 1 - 3, as well as physical exam form on page 4 with you to your physical. Give pages 1 -3 to your physician to review when he/she conducts your physical. This, along with the physical, will give him/her all the information they will need to certify whether or not you can fully participate in the intense course of study at Mission College. Your physician will need to fill out and sign page 4 of this form. **This Medical Information Form, including the physical exam on page 4 must be fully and accurately completed and then returned to the Mission College of Evangelism office before your application can be processed.** Mail completed form to: Mission College of Evangelism, P.O. Box 769, Gaston, OR 97119.

Personal Information

Full Name:_____ Gender: Male Female
Last *First* *Middle Initial*

Street Address or P.O. Box:_____

City:_____ State:_____ Zip:_____

Telephone Number:_____ Alternate Phone Number:_____

Do you have any physical limitations that would make keeping pace with an intense program difficult? *(circle one)* Yes No

If yes, briefly describe:_____

_____

Medical History

Have you ever in childhood, youth, or adulthood, had or currently have any of the following? Please check YES to all that apply. For all yes answers, underline the item in each series to which you are answering yes. Then, please note in the space provided, following the questions, (1) the number of the question, (2) the illness referred to, and (3) the date, duration, and outcome. If you need more space, use a separate sheet of paper. Giving full answers will save delay in the processing of your application.

	YES	NO	
1	___	___	Allergies, sinus trouble, hay fever, hives?
2	___	___	Anemia, hemophilia (free bleeder), easy bruising, or any blood disorders?
3	___	___	Dermatitis, psoriasis, exzema, athlete's foot, ringworm, lupus, or any skin disorder?
4	___	___	Respiratory trouble, emphysema, asthma, bronchitis, pneumonia, cancer, or any lung disorder?
5	___	___	Heart trouble, heart attack, congestive heart failure, angina, shortness of breath going up stairs, swelling of the ankles, chest or left arm pain, heart murmur, pacemaker?
6	___	___	Eye trouble, glaucoma, poor vision, glasses?

Yes No

7 ___ ___ Diabetes, hypoglycemia, any trouble with blood sugar?
8 ___ ___ Head injury, frequent headaches, stroke, Bell's palsy?
9 ___ ___ Seizures, epilepsy, fainting or dizzy spells?
10___ ___ Liver trouble, hepatitis A (infectious), hepatitis B (serum), cirrhosis?
11___ ___ High blood pressure, racing pulse, hyperventilation?
12___ ___ Nervous disorders, schizophrenia, neurosis, psychosis, mental trauma?
13___ ___ Have you ever been admitted for psychiatric treatment? Have you ever been treated or seen by a psychiatrist, psychologist, social worker, or counselor as an in or outpatient?
14___ ___ Night sweats, fever?
15___ ___ Joint pain, arthritis, rheumatoid arthritis, broken bones?
16___ ___ Back trouble/pain, neck pain/trouble, fractured back, paralysis?
17___ ___ Rheumatic fever, scarlet fever, sickle cell disease?
18___ ___ Thyroid disease, hypothyroid, hyperthyroid, thyroid crisis, thyroid surgery?
19___ ___ Tuberculosis (TB)
20___ ___ Unexplained weight loss, weakness, tiredness, chronic fatigue syndrome, and fibromyalgia?
21___ ___ Venereal disease (Syphilis, gonorrhea, etc.)
22___ ___ Jaundice
23___ ___ Any kidney trouble, bladder infections, kidney infections, blood in the urine, kidney transplant?
24___ ___ Stomach or intestinal trouble, Crohn's Disease, colitis, frequent bouts of diarrhea, nausea, vomiting, indigestion, hiatal hernia, ulcers, etc.?
25___ ___ Cancer? Please specify below.
26___ ___ Any broken bones? Please list below the date, cause, and outcome.
27___ ___ Any accidents? Please list below the date, cause, and outcome.
28___ ___ Any surgery? Please specify type of surgery, the date, and the outcome.
29___ ___ Are you now or have you ever been under the care of a physician? Please specify below.
30___ ___ Are you allergic to any medications or to any substance? Please list below if yes.
31___ ___ Are you now taking any medication? Please specify below.
32___ ___ (If female) Are you pregnant? What trimester? How many children do you have?
33___ ___ Have you ever abused any substance? How recently? Treatment? Outcome? Please specify below.
34___ ___ Have you ever suffered from or been treated for depression? Please specify below.
35___ ___ Have you ever experienced any significant mood swings? Please specify below.
36___ ___ Childhood diseases? (mumps, measles, chickenpox, whooping cough, etc.) Please list below.
37___ ___ Dental trouble/problems?
38___ ___ Please list below any other medical or dental information that is not specifically mentioned.

Number of Question Illness Referred To/Date, Duration, Outcome

#( )_____

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Applicants Signature

I certify that the information that I have provided on this form is true and correct. I realize that falsification of any information I provide to Mission College of Evangelism is grounds for immediate dismissal, without refund.

Signature:_____ Date:_____

Print Name:_____

Physical Exam Form

To be filled out by Physician

Name_____Date_____

Height_____ Weight _____Temp._____Pulse_____Resp._____BP_____

General Appearance_____

Skin_____Scalp_____

Eyes_____Vision_____Rt_____Lt_____

Ears_____Hearing_____Rt_____Lt_____

Nose_____

Mouth_____Teeth_____

Pharynx_____

Neck_____

Lymph Nodes_____

Thorax_____Breasts_____

Heart_____Size_____Sounds_____

Lungs_____

Spine_____

Abdomen_____

Genitalia_____

Rectum_____

Extremities_____

Reflexes: Knee_____Ankle_____Plantar_____

Personality_____

I certify that the above individual is able to participate without limitations in a full class load and in physical education activities.

_____ _____

Signature of Physician Date

_____

Printed Name of Physician or Physician Stamp