

# MEDICAL REPORT

## TO THE APPLICANT

Please complete the first two pages of this report yourself. Then take it to your General Practitioner or other Doctor who has recently looked after you and have him/her complete the last page.  
*(The doctor is entitled to charge a fee for this service, for which you are responsible)*

**NAME OF APPLICANT:** \_\_\_\_\_

**CURRENT ADDRESS:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**LOCATION APPLIED FOR:** \_\_\_\_\_

**STARTING DATE:** \_\_\_\_\_

## GENERAL HEALTH

Are you able to walk up to six miles a day?  YES  NO

Are you able to carry out physical work?  YES  NO

Are you currently in good health?  YES  NO

## FOR WOMEN ONLY

Have you had any conditions with menstrual periods or pregnancy?  YES  NO

## MEDICAL HISTORY

Please answer the following questions as fully as possible:

**List all the serious illnesses and operations you have had in the past with dates** (this means any illness requiring hospital admission, treatment from your doctor for an illness lasting more than one month, or any illness which may have an affect on your current health). Please also state the outcome and whether there are any residual conditions.

---

---

**List any serious illness in your family:**

---

---

**Do you have any allergies/health needs?**

---

---

**Describe any current medical conditions for which you are receiving treatment:**

---

---

**Do you have any medical conditions that affect your long term health?**

---

---

**List any medications which you take, either on a regular basis, or only when needed:**

---

---

**What is your height?** \_\_\_\_\_ **What is your weight?** \_\_\_\_\_

**Describe any current psychiatric conditions for which you are receiving treatment or have received treatment in the past** (eg. anxiety, depression, panic attacks, eating disorders)

---

---

**Is there any other information which will be helpful for us to know?**

---

---

## APPLICANT'S RELEASE OF MEDICAL INFORMATION

I \_\_\_\_\_ (print applicant's name) **give permission for the release of relevant medical information to the Year For God Medical Officer prior to training.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

When you have completed this report, take it to your doctor who will complete the rest. Please give your doctor a stamped addressed envelope so that he/she can post it directly to us.

**TO BE COMPLETED BY THE DOCTOR WHO  
HOLDS YOUR MEDICAL RECORDS**

Please send this form to: YFG Coordinator, c/o: YWAM Derby,  
Overdale House, 96 Whitaker Road, Derby, DE23 6AP, UK



**MEDICAL REPORT**

**CANDIDATE DETAILS**

**Name of applicant:** \_\_\_\_\_

Would you please verify the medical history supplied by the applicant and make any additions or comments as appropriate. The purpose of this report is to assess suitability for training in the UK with further training and practical placements overseas, usually living and working in basic conditions.

**Past history:** \_\_\_\_\_

\_\_\_\_\_

**Relevant family history:** \_\_\_\_\_

\_\_\_\_\_

**Current medication:** \_\_\_\_\_

\_\_\_\_\_

**Weight and general fitness:** \_\_\_\_\_

\_\_\_\_\_

**General health:** \_\_\_\_\_

\_\_\_\_\_

**Is the applicant free from infectious diseases?** \_\_\_\_\_

**Has the applicant had any allergic reactions?** \_\_\_\_\_

**Does the applicant have an existing condition that requires them to be in close proximity to medical facilities?** If yes, please comment

\_\_\_\_\_

**Is there any other relevant information we should be aware of?** \_\_\_\_\_

\_\_\_\_\_

**Doctor's Signature:** \_\_\_\_\_

**Name and address of Practice:** \_\_\_\_\_

\_\_\_\_\_