



วายแวมประเทศไทย
Youth With A Mission
Thailand

Foundations for Counseling Ministry (FCM)

P.O. Box 20 Thungsetthi,
Bangkok, 10263 Thailand
Tel: +66 2 752 8180 Fax: +66 2 752 8014
Email: fcmthailand@gmail.com

PHYSICIAN'S EVALUATION FORM

PHYSICIAN'S RECOMMENDATION

☐ Acceptable without limitations

☐ Not Acceptable

☐ Acceptable with limitations (specify) _____

☐ Should remain in areas where adequate medical care is provided.

PHYSICIAN'S NAME: (print) _____ Office Phone: _____

Office Address: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

Day/Month/Year

CURRENT IMMUNIZATION RECORD:

Note to the applicant: Please fill out your current immunization status, below, for our records. Upon acceptance, YWAM- Foundations for Counseling Ministry School will send you all the necessary information for any further required immunizations that you will need for outreach purposes, which you will then need to acquire before arrival at YWAM Thailand. Please be prepared financially to cover the cost of any further required immunizations. If you have ever been vaccinated for cholera, typhoid, or yellow fever, please bring that information with you to YWAM Thailand.

DISEASE	BASIC (CHILDHOOD IMMUNIZATIONS)			BOOSTER (ADULT IMMUNIZATIONS)		
	day/month/year	day/month/year	day/month/year	day/month/year	day/month/year	day/month/year
Diphtheria	/ /	/ /	/ /	/ /	/ /	/ /
Tetanus	/ /	/ /	/ /	/ /	/ /	/ /
Pertussis	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Rubella	/ /	/ /	/ /	/ /	/ /	/ /
Measles	/ /	/ /	/ /	/ /	/ /	/ /
Mumps	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis A	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	/ /	/ /	/ /	/ /	/ /	/ /

Note: If you were born after 1957, you need a measles booster (2 measles immunizations). Those born before 1957 are considered immune from measles. You need to have had a Diphtheria/Tetanus (DT) booster within the last 5 years.

Date of last DT booster: _____ (must be within 5 years)
day/month/year

Other immunizations/vaccinations you've received:

Disease: _____ Date: _____ Disease: _____ Date: _____

Disease: _____ Date: _____ Disease: _____ Date: _____

Disease: _____ Date: _____ Disease: _____ Date: _____

Please include with your application photocopies of your actual immunization record cards if possible, including any travel immunizations you have received.



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PHYSICIAN'S EVALUATION

Please review the information that the applicant filled out on the Health History Form. Please treat all conditions that you feel require treatment and notify us of any problems that you feel merit follow-up by the health service. As certain conditions such as diabetes, epilepsy, heart disease, and obesity may affect acceptance, please ensure that any pertinent information in these areas have been included.

EXAMINATION RESULTS:

Height: _____ Weight: _____ Overweight/underweight: _____

Blood Pressure: _____ Pulse: _____ E.C.G. (if over 40) _____ Blood Type: _____

Visual Acuity (without corrective lenses): Right: _____ Left: _____ With corrective lenses: Right: _____ Left: _____

Urinalysis: _____ Last Pap Smear (not compulsory): _____

Are there any abnormalities of the following systems? Please describe fully:

E.N.T. _____

Ophthalmological _____

Teeth _____

Neurological _____

Cardiovascular _____

Respiratory _____

Musculoskeletal _____

Endocrine _____

Lymphatic _____

Dermatological _____

Hernial Orifices _____

Urological _____

Psychiatric _____

Recommendations for Follow-up Tests/Treatment: _____

How long has this patient attended your office? (years & months) _____

Additional comments: _____

Please return all forms to:

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