

# PHYSICIAN'S EVALUATION FORM

Applicant's Name \_\_\_\_\_  
*Last Name* *First Name* *Middle* *Preferred*

School/Program/Position Applying For: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_  
*Street* *City* *Prov./State* *Postal (Zip) Code* *Country*

Phone numbers: \_\_\_\_\_ Email: \_\_\_\_\_  
*Daytime* *Evening*

## 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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/KKI Thailand 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 (total of 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: \_\_\_\_\_

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.



วายแวมประเทศไทย  
Youth With A Mission  
Thailand

**Bangkok**