Youth With A Mission

CAMPUS MINISTRY TANZANIA

HEALTH FORM

TO BE FILLED IN BY A QUALIFIED PHYSICIAN/MEDICAL DOCTOR

This information is treated confidentially and separate from your academic records. When you fill in your name give this form to a physician to examine you, fill in the form and sign it.

Students name _____

Family/last first Middle

Please make any comments or addition on:

1. Past medical history _____
2. Relevant family history_____
3. Current medication _____
   _____
4. Height _____ weight _____
5. In your opinion the applicant presently in good healthy? [ ] Yes [ ] No
   If No, please specify_____
   _____
6. Please give details if the applicant has had a problem with:
   a. Epilepsy or fits b. Anaemia c. Hypertension or heart disease

   d. Psychiatric problems e. Adverse reaction to stressful situations

   _____

   _____
7. Is the applicant free from **INFECTIOUS DISEASES?** [ ] Yes [ ] No
   (Specify) _____
   _____
8. Has the applicant has any ALLERGIC REACTION? [ ] Yes [ ] No
   (Specify) _____
   _____
9. Is there any other **RELEVANT INFORMATION**, which we need to know before accepting the applicant? [ ] Yes [ ] No
   If yes, please specify _____

   Doctor's name: _____ Phone: _____
   Address: _____
   Doctors Signature: _____

   Practice stamp:

   Date: _____
   Day/month/year