HEALTH HISTORY:

Health information you provide is confidential and will be used to provide safe and informed care if a medical issue arises during the mission trip. Check all that apply and provide information as requested.

Medical Problem	Explain	Medications/Treatments
☐ **Abdominal conditions**	☐ **Crohn's Disease** ☐ **Gastric Reflux** ☐ **Irritable Bowel Syndrome** ☐ **Other**	
☐ **Allergy**	☐ **Insect stings** ☐ **Latex** ☐ **Seasonal** ☐ **Food** _____ ☐ **Other** _____	**Symptoms/Reaction:** **EpiPen?** ☐ **Yes** ☐ **No**
☐ **Asthma** ☐ **Other respiratory** _____	**Under medical care now?** ☐ **Y** ☐ **N**	
☐ **Behavioral, Emotional, Psychological**		
☐ **Blood disease / disorder**		
☐ **Diabetes**	☐ **Type 1** ☐ **Type 2**	
☐ **Ears, Eyes, Nose**	☐ **Hearing Loss** **Hearing aid(s)** ☐ **R** ☐ **L** ☐ **Vision Loss not corrected by glasses or contacts** ☐ **Other** _____	
☐ **Heart condition/ heart surgery**		
☐ **Neurological disorder**	☐ **Migraines** ☐ **Cerebral Palsy** ☐ **Spina Bifida** ☐ **Other** _____	
☐ **Muscle, bone, joint condition**	☐ **Arthritis** ☐ **Muscular Dystrophy** ☐ **Scoliosis** ☐ **Other** _____	
☐ **Skin condition**		
☐ **Seizures**		
☐ **Other health conditions/ surgeries**		
☐ **Other medications (not listed above)**	**Reason:**	**Medication:**

PHYSICAL EXAMINATION FORM:

Mission trip participants must be in reasonable good health to travel on a FBW mission trip. This Physical Examination Form must be completed prior to participation.

You may utilize Clinic for the Cities to obtain the examination at no cost to you.

Mission Trip Participant: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Physician Name: _____ Phone: _____

Height _____ Weight _____ Pulse _____ BP _____

Medical	Normal	Abnormal Findings
Appearance		
Eyes/Earns/Nose/Throat		
Lymph Nodes		
Heart-Auscultation of the heart in the supine position.		
Heart-Auscultation of the heart in the standing position		
Heart-Lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Skin		
Musculoskeletal		

CLEARANCE

☐ Cleared for travel.

☐ Cleared for travel after completing an evaluation or rehabilitation for: _____

_____

☐ Travel Restricted; please explain: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic.

Examiner's Name (please print): _____ Date of Examination: _____

Signature: _____