

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

There have been no significant changes to my health condition since the date of my last physical examination on _____.

Signature: _____ Date: _____

If the date of your last examination is greater than 24 months, a new physical examination signed by a physician is required. See the form on the next page.

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 once every two years 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/Ears/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: _____