HEALTH FORM

TO THE APPLICANT: This health form is treated as confidential.

Please choose one: Trainee _____ Staff _____Volunteer _____ Team _____

NAME _____ DATE OF BIRTH_____AGE_____

ADDRESS_____

EMAIL_____PHONE _____

DO YOU HAVE MEDICAL INSURANCE THAT COVERS YOU IN HAWAII? _____YES _____NO

PROVIDER_____INSURANCE NUMBER_____

START DATE_____EXPIRY DATE_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____RELATIONSHIP_____

ADDRESS_____

EMAIL_____PHONE_____

ARE YOU TAKING MEDICATIONS? (PLEASE LIST) _____

IMMUNIZATIONS List all childhood and booster immunizations below. If you have a copy of your records please attach separately.

	DATE/YEAR	**YEAR YEAR YEAR YEAR**	**YEAR**
Diphtheria			
Tetanus			
Pertussis			
Measles			
Mumps			
Rubella			
MCV*			

- **MCV is not needed if you are over 21, however if you have had it previously, please list dates.*

MENTAL HEALTH & ADDICTIONS

Do you currently or have you previously had any of the following?

YES - NO

☐ ☐ Alcohol Addiction ☐ ☐ Drug Addiction ☐ ☐ Depression

☐ ☐ Self Harm ☐ ☐ Bipolar ☐ ☐ Eating disorder

☐ ☐ Anxiety ☐ ☐ Other_____

PERSONAL HISTORY

YES - NO

☐ ☐ Skin Condition	☐ ☐ Heart trouble	☐ ☐ Jaundice	☐ ☐ Eye trouble
☐ ☐ High Blood pressure	☐ ☐ Hepatitis	☐ ☐ Ear trouble	☐ ☐ Low blood pressure
☐ ☐ Retinal trouble	☐ ☐ Head injury	☐ ☐ Rheumatism/arthritis	☐ ☐ Headaches
☐ ☐ Back problem	☐ ☐ Diabetes	☐ ☐ Paralysis	☐ ☐ Epilepsy
☐ ☐ Dislocation of joints	☐ ☐ Kidney disease	☐ ☐ Fainting spells	☐ ☐ Broken bones
☐ ☐ Anemia	☐ ☐ Mental disorders	☐ ☐ Shortness of Breath	☐ ☐ Venereal disease
☐ ☐ Tumor/cancer	☐ ☐ Insomnia	☐ ☐ Stomach/duodenal ulcer	

SURGERY

Please list any surgeries you have undergone:_____

ALLERGIES

Please list any and all allergies:_____

FEMALES ONLY

YES - NO

☐ ☐ Irregular periods ☐ ☐ Severe cramps ☐ ☐ Pregnant

FAMILY HISTORY

Have any of your relatives ever had any of the following:

YES - NO

☐ ☐ Diabetes ☐ ☐ Arthritis ☐ ☐ Epilepsy/convulsions ☐ ☐ Kidney Disease ☐ ☐ Stomach Disease

☐ ☐ Cancer ☐ ☐ Heart Disease ☐ ☐ Hypertension ☐ ☐ Asthma/hay fever

==========

To be filled out and signed by a physician:

1. Can he/she walk up to five miles per day carrying a 15 pound sack? No_____

Yes_____ 2. Is he/she underweight or overweight? _____ 3. Is he/she

under medical attention or taking medicine? No_____ Yes_____ If yes, please explain:

_____ 4. Is

the applicant in general good physical health? No_____ Yes_____

5. Is the applicant in general good mental health? No_____ Yes_____

6. Does the applicant have any contagious illness? No_____ Yes_____ If yes, please

explain:_____

PHYSICIAN'S SIGNATURE_____DATE_____

PHYSICIANS NAME_____ADDRESS_____

PHONE_____EMAIL_____