



HEALTH HISTORY FORM

The Salvation Army
USA Eastern Territory



THE SALVATION ARMY
RAILTON SCHOOL FOR YOUTH WORKER TRAINING
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Completion and return of this form to Railton School for Youth Worker Training is a requirement for enrollment. It is necessary to have this form returned by August 20, 2007.
Applicants are to fill out pages 1, 2, & 3; physicians are to fill out pages 4, 5, & 6.

IDENTIFICATION

Social Security Number: _____

Name: _____

Home Address: _____

Telephone #:(_____) _____

Birth Date: _____ Sex: ____M ____F

Father's Name: _____

Mother's Name: _____

EMERGENCY CONTACT

Name of Contact Person: _____

Relationship to Applicant: _____

Home Telephone:(_____) _____

Work Telephone:(_____) _____

Cell Phone:(_____) _____



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FAMILY HISTORY: TO BE COMPLETED BY THE APPLICANT

	Age	State of Health	Occupation	Age at Death	Cause of Death	Have your parents/ grandparents/ siblings had any of the following?	Yes	No	Relationship
Father						Arthritis			
Mother						Asthma, Hay Fever			
Brothers						Cancer			
						Diabetes			
						Epilepsy, Convulsions			
						Heart Disease			
						High Blood Pressure			
Sisters						Kidney Disease			
						Mental Illness			
						Stroke			
						Tuberculosis			

GENERAL HEALTH: (PLEASE GIVE DETAILS BELOW FOR ANY)

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Endocrine/Metabolic Dis.			Allergy To:			Heart Murmur		
Measles			Skin Conditions			Penicillin			Gall Bladder Trouble		
German Measles			Diabetes			Sulfonamide			Hernia		
Mumps			Convulsive Disorder			Serum			Gastro-Intestinal Problems		
Chicken Pox			Cerebral Palsy			Foods (specify)			Jaundice/Hepatitis		
Malaria			Cystic Fibrosis			Other (specify)			Cancer		
Mononucleosis			Tuberculosis			Surgery:			Disease/Injury of Joints		
Rheumatic Fever			Asthma			Appendectomy			Orthopedic Problems		
High Blood Pressure			Frequent Colds/Sinusitis			Tonsillectomy			Back Problems		
Blood Disorders			Hay Fever			Other (specify)			Urinary Tract Infections		
Anemia			Impaired Vision			Recurrent Headaches			*# of Recurrences		
Anorexia Nervosa			Corr. Lenses Worn			Head Injury/ Unconsciousness			Venereal Disease		
Bulimia			Ear, Nose, Throat Problems			Alcohol/Drug Problems			If Female:		
Weight Loss/Gain			Impaired Hearing			Palpitations (Heart)			Gynecologic Problems		

Explanation:



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MEDICAL HISTORY: PLEASE ANSWER ALL QUESTIONS. EXPLAIN ALL "YES" ANSWERS.

	Yes	No	Explanation:
A. Has your physical activity been restricted during the past five years?			
B. Have you had any illness or injury or been hospitalized other than already noted?			
C. Do you have an on-going health problem which has required treatment by a physician or other health care provider in the past five years?			
D. Have you received treatment by a psychiatrist or clinical psychologist?			
E. Do you take any medication on a regular basis? If so, please list name(s) and dosage(s).			
F. Disability: Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the School? If so, circle the appropriate disability below and give specifics:			

Visual Motor Learning Hearing Emotional Others (list)

Explanation:

Signature of Applicant

Signature of Physician (Acknowledging Review)

Date



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PHYSICIAN'S PART 1: TO BE COMPLETED BY HEALTH CARE PROVIDER AND SIGNED

Height:	Weight:	Blood Pressure:	Pulse:
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PHYSICAL EXAM: ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?

	Yes	No	Comments
Head, Ears, Nose, or Throat			
Eyes Ophthalmoscopic			
Hearing			
Neck – Thyroid			
Cardiovascular			
Respiratory			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Do you have any recommendations regarding the physical or emotional care of the student?

_____ Yes _____ No

If yes, specify here or attach them:

Upon completion of a Physical exam I have found _____ to be capable of participation in the ministry training program. _____ Yes _____ No

Provider's Signature _____ Date _____

Print Provider's Name _____ Phone #:(_____) _____

Provider's Address _____



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PHYSICIAN'S PART 2: IMMUNIZATION RECORDS

New York State requires signed proof of 2 measles, 1 mumps, and 1 rubella all given after 1968 and after the 1st birthday. Students born before 1957 are exempt from this requirement.

MMR's given on #1 ___/___/___ #2 ___/___/___
M D Y M D Y

Or A, B, and C

A. 1) Two dates of Measles immunization #1 ___/___/___ #2 ___/___/___
M D Y M D Y

Or 2) Date of positive measles titer #1 ___/___/___
M D Y

(results must be attached)

Or 3) Date of Physician Diagnosis #1 ___/___/___
M D Y

B. 1) Date of Mumps immunization #1 ___/___/___
M D Y

Or 2) Date of positive mumps titer #1 ___/___/___
M D Y

Or 3) Date of Physician Diagnosis #1 ___/___/___
M D Y

C. 1) Date of Rubella immunization #1 ___/___/___
M D Y

Or 2) Date of positive rubella titer #1 ___/___/___
M D Y

(history of rubella not acceptable)



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TUBERCULIN SCREENING (PPD MANTOUX REQUIRED REGARDLESS OF PRIOR BCG)

1. PPD (Mantoux within past 12 months – Tine or Monovac not acceptable) Date Test Administered . . . __/__/__
Result: Neg__ Pos__ ____MM Induration Date Test Read __/__/__

TETANUS DIPHTHERIA

TETANUS DIPHTHERIA Series completed __/__/__ Booster (within 10 years) . . __/__/__

POLIO

POLIO: 1.OPV alone #1 __/__/__ #2 __/__/__ #3 __/__/__
2.IPV alone #1 __/__/__ #2 __/__/__ #3 __/__/__
3.IPV/OPV Sequential . . . IPV #1 __/__/__ IPV #2 __/__/__ OPV #3 __/__/__ OPV #4 __/__/__

VARICELLA

VARICELLA: 1. History of Disease ____Yes ____No
2. Titer __/__/__ Reactive____ Non-reactive____
3. Immunization . . . #1 __/__/__ #2 __/__/__ Given one month after first dose if age 13 years or older

HEPATITIS

HEPATITIS VACCINES: Hep. A #1 __/__/__ #2 __/__/__
Hep. B #1 __/__/__ #2 __/__/__ #3 __/__/__

MENINGOCOCCAL

One dose – Students less than 25 years who wish to reduce their risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine q3-5 years.

Quadrivalent polysaccharide vaccine Date __/__/__
M Y

Provider's Signature _____ Date _____

Print Provider's Name _____ Phone # (____) _____

Provider's Address _____
Street State Zip Code



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MENINGOCOCCAL MENINGITIS IMMUNIZATION

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Railton School for Youth Worker Training.

Check one box and sign below.

I have (for students under the age of 18: My child has):

had meningococcal meningitis immunization within the past 10 years.

Date received: _____

[Note: If (your child) received the meningococcal vaccine available before February 2005, called Menomune TM , please note this vaccine's lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine, called Menactra TM, should be considered within 3-5 years after Menomune TM.]

read, or have explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider or Railton School for Youth Worker Training.

read, or have explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease.

Signed _____
(Parent / Guardian if student is a minor)

Date _____

Print Student's Name _____

Student
Date of Birth _____

Student
E-Mail Address _____

Student ID# _____

Student
Mailing Address _____

Student
Phone Number _____