



Personal Health Form

> Identity

First Name: _____ Last Name: _____

Gender: Male Female Date of Birth: ___ / ___ / ____ (dd/mm/yyyy)

Place of Birth: _____ (Town/City, Country)

> Identity

It is essential that all participants of the **INS | The Journey of Sonship** have adequate medical insurance coverage for the duration of the school. If you currently have international health insurance please include the details below:

Name of Insurance carrier: _____

Policy type: _____

Policy number: _____

Insurer's Contact Phone Number: _____

Expiration Date: ___ / ___ / ____ (dd/mm/yyyy)

Brief description of coverage: _____

NOTE: Medical insurance is compulsory for all international INS participants and is also strongly recommended for all Kiwi INS participants. If you do not currently have insurance please wait until you are accepted for the school before purchasing a policy. Possible comprehensive options include:

- The Banner Group - www.bannergroup.com
- Talent Trust Consultants - www.talent-trust.com

> Personal Health History

Have you ever had, or do you have, any of the following?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> Tumour/Cancer | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Intestinal trouble |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Sight and/or Hearing loss | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay fever/Asthma |
| <input type="checkbox"/> HIV /Aids | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Professional Counselling | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Rheumatism/Arthritis |
| <input type="checkbox"/> Recurrent Diarrhoea | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Fainting Spells | |
| <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Stomach/Duodenal Ulcer | <input type="checkbox"/> Dislocation of joints | |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Back problems | <input type="checkbox"/> Hepatitis A | |



If you have answered affirmatively to any of the above please elaborate below:

> Allergies

Are you allergic to any medications? (Penicillin, Sulphonamides, etc.) Yes No

If yes, please elaborate: _____

Are you allergic to anything else? (Bee Stings, Latex, Foods, etc.) Yes No

If yes, please elaborate: _____

> Recent Surgery

Have you had any surgery(s) in the past 24 months? Yes No

If yes, please elaborate: _____

> Ladies Only

Are you pregnant? Yes No

If yes, what is the due date? ___ / ___ / ____ (dd/mm/yyyy)

> Mental/Psychological Disorders

Do you have any past or present history of mental or psychological disorders? Yes No

If yes, please elaborate: _____

Do you have any past or present history of substance abuse? Yes No

If yes, please elaborate: _____



> Medical Treatment

Are you currently receiving treatment from a doctor for any condition? Yes No

If yes, please elaborate: _____

Are you currently taking any medication? Yes No

If yes, please elaborate: _____

Do you have any disabilities or health conditions that require special attention? Yes No

If yes, please elaborate: _____

> Communicable Diseases

Have you ever had any of the following?

- Chickenpox
- Measles (Rubella)
- Mumps
- Pertussis
- Scarlet Fever
- Tuberculosis
- Other

If yes, please elaborate: _____

> Confirmation

I confirm, as far as I am aware, that the information given above is correct at the time of completing this application. If there are any changes that would affect any of my answers to the above questions between the date of application and the start of the INS, I will inform Fatherheart Ministries in writing.

Applicant's Signature: _____ Date ____ / ____ / ____ (dd/mm/yyyy)