



Physician's Evaluation Form

Dear Sir/Madam,

The applicant has applied for a intensive 3-month Christian school entitled **INS | The Journey of Sonship** organised by Fatherheart Ministries in New Zealand (see www.fatherheart.net for more info).

The school is located at the Orama Christian Centre, Great Barrier Island, New Zealand. The location at Orama is remote and living conditions are basic: shared housing, limited services and no public transportation.

The INS weekly program include 7.5 to 10 hours per week of work-duties for each participant. These duties might include: cooking, cleaning, gardening and maintenance etc.

The facilities themselves are located at the bottom of an uphill gravel driveway (a 35-minute brisk walk) and residents require a reasonable level of fitness to access local amenities. The nearest village shop is a further 45-minute walk from the mouth of the driveway (Orama has its own shop for toiletries, snacks and various sundry supplies).

For further details on the location, please visit the following websites:

www.orama.org.nz

www.inheritingthenations.com

Please could you complete the questions below and submit the form once you've finished.

Thank you,

- The INS team

INS | Physician's Evaluation Form

> Name Applicant

Please enter the full name of the APPLICANT on whose behalf you are completing this Pastor/Spiritual Leader's Reference form:

First Name: _____ Last Name: _____

> Physical Assessment

Height (meters): _____

Weight (kilograms): _____

Blood Pressure: _____



1. On the basis of your cursory physical examination and your knowledge of the applicant's medical history, are you aware of any abnormalities relative to the applicant's eyes, ears (hearing), nose, throat, cardiovascular system, respiratory system, digestive system, muscular/skeletal system, etc.? Yes No

If yes, please elaborate: _____

2. Does the applicant have any history of epilepsy or diabetes, or any other chronic illness? Yes No

If yes, please elaborate: _____

3. Is the applicant currently taking any medication? Yes No

If yes, please elaborate: _____

4. Does the applicant have any current or previous psychological disorders that would limit their ability to participate fully in community living and/or intensive studies? Yes No

If yes, please elaborate: _____

Any other comments: _____



> Immunization History

- Typhoid ___ / ___ / ____ (dd/mm/yyyy)
- Rubella ___ / ___ / ____ (dd/mm/yyyy)
- BCG ___ / ___ / ____ (dd/mm/yyyy)
- Pertussis ___ / ___ / ____ (dd/mm/yyyy)
- Hepatitis A ___ / ___ / ____ (dd/mm/yyyy)
- Hepatitis B ___ / ___ / ____ (dd/mm/yyyy)
- Polio ___ / ___ / ____ (dd/mm/yyyy)
- Mumps ___ / ___ / ____ (dd/mm/yyyy)
- Tetanus ___ / ___ / ____ (dd/mm/yyyy)

> Physician's Recommendation

In your view, how suitable is this school and environment for the applicant?

- Completely suitable
- Suitable with limitations
- Suitable provided they remain in areas where adequate medical care is provided
- Not suitable at all

Physician's Name: _____

Medical Practice: _____

Address: _____

City/Town: _____

County/State: _____ Post Code/Zip Code: _____

State/Region: _____ Email Address: _____

Telephone Number: _____ (+ country & area code) Time Zone: _____ (+/- GMT)

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

Thank you for taking the time to complete this reference. Your thoughts and input will be carefully considered and regarded as confidential.