Medical Form

Applicant Name: _____ Telephone: _____

Address: _____

_____

1. Do you suffer from any physical problems which require special consideration?
   Yes ☐ No ☐ If yes, please describe

   _____

2. Do you suffer from any physical illness? Yes ☐ No ☐ If yes, please describe

   _____

3. Do you suffer from any chronic emotional illness? Yes ☐ No ☐ If yes, please describe

   _____

4. Do you suffer from any communicable disease? Yes ☐ No ☐ If yes, please describe

   _____

5. Do you suffer from any skin disease? Yes ☐ No ☐ If yes, please describe

   _____

6. Do you suffer from allergies? Yes ☐ No ☐ If yes, what are they?

   _____

7. Do you suffer from any cardiovascular disease? Yes ☐ No ☐ If yes, please describe

   _____

8. Do you suffer from any respiratory disease? Yes ☐ No ☐ If yes, please describe

   _____

9. Do you suffer from any musculoskeletal disease? Yes ☐ No ☐ If yes, please describe

   _____

10. Do you suffer from any hearing impairment? Yes ☐ No ☐ If yes, please describe

    _____

11. Do you suffer from any visual impairment? Yes ☐ No ☐ If yes, please describe

_____

* If answered yes to any of the above questions, are you currently receiving treatment? Yes ☐ No ☐ If yes, please describe

_____

12. Do you have any history of drug or alcohol use/abuse? Yes ☐ No ☐
* If yes, are you currently receiving treatment? Yes ☐ No ☐ If yes, please describe

_____

I confirm that all answers and statements made on this form are accurate, complete, and truthful. I understand that any misrepresentation, omission, or false statement may result in removal from the program.

Signature: _____ Date: _____

Witness: _____ Date: _____