Barbados YouthADVANCE Corps

Health Assessment Form

(To be completed by the applicant)

PERSONAL INFORMATION

Last Name: …….....

First & Middle Names: ……...

Age: ……..... D. O. B.: ……Nat. Reg. #: ……
(yr/mm/dd)

Address: ……..…

……...

In case of emergency please contact:

1. Name: ……..…….
Relationship

Tel. No. (Home): …… (Work): …….....

2. Name: ……..…….
Relationship

Tel. No. (Home): …… (Work): …….....

INFORMATION TO APPLICANT

This health assessment form is part of the application process and it is the applicant's responsibility to ensure that it is completed and returned to the Barbados YouthADVANCE Corps. Any expenses related to this process must be met by the applicant. The information contained in this form will be treated with confidentiality.

I consent to the disclosure of personal medical information of ……
(myself/name of applicant)
To the Barbados YouthADVANCE Corps.

Please sign below to indicate that you have read and agree to the above**. (If the applicant is under 18 years of age a parent or guardian must sign on his/her behalf.)**

Signature: ……Date: ……..……

Print Name: ……

The next section of this form is to be completed by a Medical Practitioner. In an effort to ensure that your medical information is current, it should not be completed before the month of June in this same year. Please note that all other documents should be submitted with your application and this Health Assessment Form can be submitted after.

Barbados YouthADVANCE Corps

(Information for Medical Practitioner)

The Barbados YouthADVANCE Corps is a two year self-development programme. The programme includes an intense physical component in which all trainees are expected to participate. In addition, there is a residential phase where the trainees actually live on the compound for a stated time period. In the interest of the applicant's personal health and safety we require the following information be provided by a Medical Practitioner.

Medical Practitioner's Name: ……

Address: ……

Telephone: ……

Please indicate YES or NO for each item. Where applicable, provide any necessary information in the space provided.

GENERAL HISTORY

Does the applicant have:

Asthma	☐ Yes	☐ No ...…….……
Other respiratory problems	☐ Yes	☐ No ……..
Diabetes	☐ Yes	☐ No ...……..….
Heart Condition	☐ Yes	☐ No …….
Chest Pain	☐ Yes	☐ No …….
Hepatitis or other liver disease	☐ Yes	☐ No …….
Seizures	☐ Yes	☐ No …….
Bleeding or Blood Disorders	☐ Yes	☐ No …….

Migraines	☐ Yes	☐ No ……
Fainting Spells	☐ Yes	☐ No ……
Nose Bleeds	☐ Yes	☐ No ……
Visual Impairment	☐ Yes	☐ No ……
Skin Condition	☐ Yes	☐ No ……
Gastrointestinal Condition	☐ Yes	☐ No ……
Any other condition	☐ Yes	☐ No ……

MUSCULOSKELETAL INJURIES

Does the applicant presently have or had a history of:

Knee, hip or ankle injuries	☐ Yes	☐ No	……
Shoulder or arm injuries	☐ Yes	☐ No	……
Back Injury	☐ Yes	☐ No	……
Other joint problems	☐ Yes	☐ No	……
Head Injury	☐ Yes	☐ No	……

ALLERGIES & MEDICATION

Does the applicant have:

Any allergies	☐ Yes	☐ No	……
Allergies to any medications	☐ Yes	☐ No	……
Current medication	☐ Yes	☐ No	……
If yes, please specify medication and dosage			……

Medical Examination findings or any other comments

Do you believe that this applicant is medically fit to successfully participate in this programme?

☐ Yes ☐ No

Medical Practitioner's Signature:

……

Please print or stamp name:

……

Date:

……