



Application for Admission to the Doctor of Ministry in Leadership Program

Mail: QCCPO Box 1495, Quezon City, 1100 Philippines • Location: 12 Daisy Rd. Sauyo, Novaliches, Quezon City, 1116 Philippines
Tel. No: (632) 454-4546 to 49; 984-1210 or 1217 • Fax No: (632) 984-1954 • E-mail Address: admissions@igsl.asia

MEDICAL CLEARANCE FORM

(It is in the applicant's own interest to complete this form as honestly, completely, and as accurately as possible. If the applicant is accepted into the program, this form will be on file for reference in case of a medical emergency.)

Please type or print all information legibly.

PORTION TO BE COMPLETED BY APPLICANT:

Full Name _____ Date of Birth _____

Sex _____ Single/Married _____ Number and ages of children _____

Home Address _____

In case of Emergency, contact (give name, relation to you, contact info):

Name

Relationship

Contact information (cell or phone, email)

Family History: List major illnesses and/or causes of death of . . .

Parents: _____

Brothers or Sisters: _____

Wife or children _____

Health Insurance: Company _____ Plan Name/number _____

Contact numbers _____ Member ID Number _____

Signed: _____ Date: _____

PORTION TO BE COMPLETED BY APPLICANT'S DOCTOR:

1. How long have you known or treated this person? _____

2. Is he/she **allergic** to any drugs? ____ If so, which? _____

Any other significant **allergies** (foods, animals, etc.)? _____

3. If he/she suffers from any of the following, please encircle them:

Poor vision

Allergies

Diarrhea

Eye strain

Shortness of breath

Frequent constipation

Poor hearing

Asthma

Muscle or bone pain

Noises in ears

Bronchitis

Mental/emotional depression

Frequent headaches

Palpitations of the heart

Sleep trouble

Frequent colds, cough

Skin disease

Frequent urination

Nose bleeds

Food intolerance

Blood in urine or stool

Bleeding gums

Indigestion

Trouble with periods (if female)

Sinus trouble

Stomach pains

Chronic pain or fatigue

4. List major **surgeries** or **illnesses** (& length of time) he/she has had (e.g., diabetes, heart trouble, seizures, appendectomy)
5. If he/she is taking on **going medicines**, specify meds and purpose: _____
6. Does he/she have any **physical limitations** at all? (If so, please specify)

Examination of applicant: Height _____ Weight _____ Blood Pressure _____

Eyes _____ Visual Acuity (Right) _____ (Left) _____
Ears _____ Hearing (Right) _____ (Left) _____

Mouth _____ Throat _____
Teeth _____ Palpable Glands _____

Chest: Expansion _____ Auscultation _____

Cardio vascular system: Pulse (resting) _____ After 1 min. exercise _____
Blood Pressure _____ Heart sounds _____

Abdomen: Scars _____ Palpable organs _____
Tenderness _____ Hernias _____
Hemorrhoids _____ Other _____

Neurological: Power _____ Sensation _____
Co-ordination _____ Reflexes _____

Mental/Emotional Evaluation: Has the applicant any history of mental/emotional disorder? ___ If so, what? _____
Describe symptoms, state duration and treatment. _____
Are there currently any signs of excessive anxiety, any depression or emotional disturbance? ___ If so, please describe:

Laboratory tests: Chest X-ray (screening) _____
Blood tests _____

Please summarize important findings:

IMPORTANT: *Do you find from the applicant's history and examination any reasons to think he/she might not tolerate years of intensive mental and emotional demands, travel, and changes of diet, climate and culture?* ___ If so, please explain:

Date: _____ Signature of Doctor: _____
Printed Name of Doctor: _____

Are you the applicant's primary care physician? ___ Yes ___ No May we contact you in case of an emergency? ___ Yes ___ No

Address: _____

Office Phone: _____ Cell Phone: _____