INTERNATIONAL GRADUATE SCHOOL OF LEADERSHIP
Building Leaders for Transformation

In cooperation with the
Asia Graduate School of Theology
(AGST-Phil)

Th.M./D.Min./Ph.D. in Peace Studies

MEDICAL 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, surgeries)

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 (or 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: _______________________________