Please print this page and bring it with you to YWAM Blantyre.

IMPORTANT: If you have worked for YWAM in the past, please arrange for your most recent supervisor to send a Reference Form to the Registrar's office.

Consent for treatment

In the case of an emergency I/we hereby agree to the performance of such treatment, including anesthesia and surgery, as the attending doctor or physician may deem necessary.

Indemnity

I/We do hereby agree that I will not hold Youth With A Mission, its staff, agents and volunteer responsible for any illness, injury, damage or loss incurred by said person(s) during the course of involvement with Youth With A Mission.

Acknowledgement of financial responsibility

I/we have read and understood the Financial Policy of YWAM Blantyre. I/we understand that the payment of the required school fees must be made as set out under "Payment Plans".
Further, I/we agree to meet in a timely manner, prior to the completion of the school, all personal expenses incurred during my involvement with Youth With A Mission.

I am willing to commit myself to the YWAM leadership and co-operate with them at all times.

Applicant's signature

Today's date (DD/MM/YYYY)
Day / Month / Year

If applicant is under 18 years of age, signature of parent/guardian is also required:

Signature of parent/guardian

Today's date (DD/MM/YYYY)
Day / Month / Year

Name of parent/guardian

YWAM Blantyre

Physician's Evaluation

This form is to be completed by a doctor for the applicant of the Youth With A Mission (YWAM) Blantyre Discipleship Training School (DTS). The programme will require good health and endurance. Please fill out the portion below and make any additional comments. Thank you.

Name of Patient

Blood Pressure | **Pulse** | **CG (over 40)**

Visual acuity: Without glasses Right / Left

With glasses Right / Left

Hearing Right / Left

Are there any abnormalities of the following systems? Please describe fully.

Ears/Nose/Throat	**Eyes**	**Neurological**
Cardiovascular	**Respiratory**	**Musculoskeletal**
Endocrine	**Lymphatic**	**Dermatological**
Hernial orifices	**Urological**	**Psychiatric**

Would he/she be able to walk 5 – 10 kilometers per day? ☐ **Yes** ☐ **No**

Comments

Physician's recommendation

☐ **Acceptable without limitations** ☐ **Acceptable with limitation**

☐ **Not acceptable (should remain where adequate medical care is available)**

Physician's name (PRINT)

Address

Telephone | **Day / Month / Year**

Signature

Stamp