



PHYSICIAN'S EVALUATION - To be completed by your doctor

TO THE PHYSICIAN:

The above-named person has applied for service with YOUTH WITH A MISSION. This 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

Comment

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