Friend Ships Unlimited

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PHYSICAL WELLNESS

*** IMPORTANT *** *Answer every question and ☑ check boxes that apply.* This form must be received along with the application in order to process your paperwork. Please answer honestly and openly. Please use additional paper if needed.

All applicants are prayerfully considered so your responses will not automatically disqualify you.

CONDITION OF HEALTH *(Please check ☑)*: ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT

Do you have any Allergies: ☐ Yes, or ☐ No **If Yes,** please list:_____

Health Conditions: Please ☑ check the boxes that apply to the following conditions you have or had.

Asthma ☐ Have or ☐ Had	**Tuberculosis** ☐ Have or ☐ Had	**Circulatory Problems** ☐ Have or ☐ Had
Hepatitis ☐ Have or ☐ Had	**HIV Virus/Aids** ☐ Have or ☐ Had	**Heart Problems** ☐ Have or ☐ Had
Epilepsy ☐ Have or ☐ Had	**Claustrophobia** ☐ Have or ☐ Had	**Diabetes/Hypoglycemia** ☐ Have or ☐ Had
Mental Illness ☐ Have or ☐ Had	**Depression** ☐ Have or ☐ Had	**Back Problems** ☐ Have or ☐ Had
Eating Disorder ☐ Have or ☐ Had		**Other:**_____ ☐ Have or ☐ Had

How many **Sick days** have you taken off from work/school in the last year *(Your best estimation)*:_____ Day(s)
Please explain:_____

PHYSICAL CONDITIONS: Please ☑ check yes or no to the following. Explain any limitations or accommodations required.

Can you lift and carry 20 pounds repeatedly? ☐ Yes or ☐ No If No, please comment:_____

Can you climb two or more flights of ladders? ☐ Yes or ☐ No If No, please comment:_____

Can you stand for at least two hour periods? ☐ Yes or ☐ No If No, please comment:_____

Can you sit for long periods? ☐ Yes or ☐ No If No, please comment:_____

Can you work and live with little or no privacy? ☐ Yes or ☐ No If No, please comment:_____

Can you tolerate extreme heat and humidity? ☐ Yes or ☐ No If No, please comment:_____

Can you tolerate extreme cold? ☐ Yes or ☐ No If No, please comment:_____

Can you tolerate areas with mold and mildew? ☐ Yes or ☐ No If No, please comment:_____

Can you sometimes work 12 hour shifts/nights/weekends? ☐ Yes or ☐ No If No, please comment:_____

Do you require special food items/diet/timing of meals? ☐ Yes or ☐ No If Yes, please comment:_____

Do you require access to specialized medical care? ☐ Yes or ☐ No If Yes, please comment:_____

Do you require air conditioning? ☐ Yes or ☐ No If Yes, please comment:_____

We may request information from your physician regarding any significant medical and/or emotional problems that currently affect you. Correction of any problems regarding vision, hearing or dental care should be completed before joining Friend Ships, if possible.

I CERTIFY THAT I HAVE ANSWERED THE QUESTIONS FULLY AND HONESTLY AND THAT I HAVE NO OTHER SIGNIFICANT HEALTH PROBLEMS.

Signature:_____ Date:_____

Are you presently taking any prescriptions? ☐ Yes, or ☐ No
If Yes, fill out the below "Medical Information and Agreement".

MEDICAL INFORMATION AND AGREEMENT

You must answer every question. Please use blue or black ink and print neatly. Thank you!

Note: This form is only used for ongoing permanent or semi-permanent conditions including (but not limited to) epilepsy, bipolar disorder, clinical depression, schizophrenia, alcoholism, drug addiction, diabetes, cardiac conditions, hypertension, asthma, and acute allergies. Do not include temporary conditions and medicines such as antibiotics for infections or antihistamines for transient or seasonal allergy conditions such as hives, hay fever, etc.

INFORMATION:

I, _____, have been diagnosed by a medical doctor with the following medical condition *(s)*
(Your Full Name)
listed by name with the year of diagnosis:

1._____ 2._____
3._____ 4._____
Additional Notes:_____

I am presently taking the following medication*(s)* to control the above condition*(s)*:
List Drug Name, Strength, Dosage and Frequency:

1. _____ Year First Prescribed:_____
2. _____ Year First Prescribed:_____
3. _____ Year First Prescribed:_____
4. _____ Year First Prescribed:_____
5. _____ Year First Prescribed:_____
6. _____ Year First Prescribed:_____

AGREEMENT:

I agree to inform the Facility Manager and nurse **BEFORE** stopping this *(these)* medication*(s)* or **BEFORE** changing the frequency and/or dosage without a medical doctor's directive. Further, if a medical doctor directs me to stop or change this *(these)* medication*(s)*, I agree to inform the Facility Manager **IMMEDIATELY**. I fully understand that failure to honor this agreement by promptly informing the Facility Manager may result in my dismissal from Friend Ships.

Signed by:_____ Date:_____

Witnessed by:_____ Title:_____ Date:_____