POWER BIBLE SCHOOL

Medical Assessment

STUDENT HEALTH REQUIREMENTS

As part of the admissions process for Power Bible School, students are required to provide a completed Medical Assessment which includes a Medical History, a Physical Examination and Physician's Recommendations for Exercise. All responses must be in English.

You are required to provide this information to attend PBS. Please complete this form with your health care provider and return it either by mail or personal delivery to:

Power Bible School
Abel Damina Ministries International
98, Nwaniba Road
P. O. Box 2901
Uyo
Akwa Ibom State
Nigeria
Office: +234-806-800-9939 or +234-803-275-6104

GENERAL INFORMATION

Applicant's Name: ____

Gender: ________Date of Birth: __________Place of Birth:___________

Present Address ____

Telephone Number(s): ____

Emergency Contact: Please provide the name, relationship, and phone numbers of a family member or other person to be contacted on your behalf in an emergency:

____ ______________

Name *Relationship* *Home or Cell Phone* *Work or Cell Phone*

AUTHORIZATION AND PERMISSION (To be signed by student)

I authorize Power Bible School at its discretion, acting by its medical staff or by one of its officers, to make provision on my behalf, with any reputable physician, hospital, or clinic for medical care and treatment, including surgery, anesthesia, diagnostic, and therapeutic procedures as maybe deemed necessary for said treatment.

I hereby give my permission to any physician, medical clinic, or hospital to release any information to Student Health Services at Power Bible School.

____________________________ ____________________________

Printed Name of Student *Signature of Student*

____

Date

Name:____

STUDENT'S PAST AND PRESENT MEDICAL HISTORY

1. Are you currently under a doctor's care? ❑ Yes ❑ No (If yes, please explain and give physician's name and address below)

2. list prescribed medications you are taking:____

3. List any physical challenges:____

Yes No	1	Head injury or concussion	Yes No	28	Liver problems, hepatitis, cirrhosis
Yes No	2	A "stroke"	Yes No	29	Diabetes
Yes No	3	Epilepsy (seizures,	Yes No	30	Sickle cell disease or trait
Yes No	4	Treatment for emotional or	Yes No	31	Malaria, other tropical diseases
Yes No	5	Frequent trouble sleeping	Yes No	32	Enlarged lymph gland
Yes No	6	Attempted suicide	Yes No	33	Cancer
Yes No	7	Frequent or severe	Yes No	34	Cysts or tumors
Yes No	8	Meningitis	Yes No	35	Kidney or bladder problem
Yes No	9	Glasses or contacts	Yes No	36	Rectal bleeding, fissure, abscess
Yes No	10	Eye problems, glaucoma,	Yes No	37	Colitis or chronic constipation
Yes No	11	Hearing loss, freq. ear	Yes No	38	High blood pressure
Yes No	12	Mouth or throat problems,	Yes No	39	Venereal disease
Yes No	13	Nose problems, hay fever	Yes No	40	Alcoholism
Yes No	14	Thyroid	Yes No	41	Hernia or hernia repair
Yes No	15	Chest pain, chronic cough,	Yes No	42	Weight problems
Yes No	16	Difficulty breathing,	Yes No	43	Anaemia it blood disorder
Yes No	17	Tightness in chest	Yes No	44	Back, neck, or spine problems, disc
Yes No	18	Asthma, emphysema,	Yes No	45	Broken Bones
Yes No	19	Tuberculosis (TB,	Yes No	46	Need to wear back brace or support
Yes No	20	Heart problems, night	Yes No	47	Joint problems, arthritis, bursitis
Yes No	21	Breast problems, lump in	Yes No	48	Joint injuries, knee, shoulder, etc.
Yes No	22	Chronic recurring	Yes No	49	Ankle or leg swelling, cramps,
Yes No	23	Skin problems or rashes	Yes No	50	Foot problems
Yes No	24	Chronic indigestion,	Yes No	51	Clnldl.00d diseases (measles,
Yes No	25	Abdominal pain	Yes No	52	History of drug abuse
Yes No	26	Hiatal hernia, gallbladder	Yes No	53	Other
Yes No	27	Ulcer, stomach problems	Yes No	54	Other

Please explain any "yes" answer above and give approximate dates.

*___ Date____
*___ Date____
*___ Date____
*___ Date____
*___ Date____
*___ Date____

Please list any known allergies for which you might require medication or preventive measures (include food, dust, drugs, soaps, pollens, detergents,
chemicals):____
____

Physician's Recommendations for Exercise (Io *be completed by physician)*
❑ NO Restrictions for an exercise program. ❑ Restriction recommendation as follows:
Due to the nature of this student's injury, illness, or physical limitation (specify)______________________
I advise that physical education activities be restricted:
Less than 6 weeks __________________ More than 6 weeks_________________Permanently_____________
The following activities ARE recommended for this individual:

❑ walking	❑ cycling	❑ weight training/calisthenics
❑ jogging	❑ stationary cycling	❑ arm, crank exercise
❑ swimming	❑ sports activities	❑ supervised treadmill walking

This form MUST be signed (or stamped) by Health Care provider in order to be valid. HEALTH CARE PROVIDER
Name:_______________________________ Phone:____
Address: ____ _________________________
Physician's Signature

P O W E R B I B L E S C H O O L

98 Nwaniba Road P.O. Box 2901 Uyo, Akwa Ibom State, Nigeria.+234-806-800-9939
E-mail: powerbibleschool@gmail.com Website: www.powercityinternational.org

Recommendation

Applicant's Name:____

Last/family Name *first/Given Name* *Middle Name*

The above named person has applied for enrollment as a student at Power Bible School. Serious consideration will be given to your comments on this form. As we require a candid evaluation, your remarks will be held in strict confidence. So please return in sealed envelope.

DETAILS OF REFEREE

Name *(surname first)*:____

Address:____

E-mail:____

Telephone Number *(s)*:____

EVALUATION OF APPLICANTS

Relationship

How long have you known the applicant?____

Relationship: Pastor____ Personal friend___Co-worker______Ministry friend____Other (specify)

Evaluate Applicant's Character and Lifestyle: Tick G for Good, F for Fair, P for Poor and U for unknown

Christian life and testimony: G_F_P_U_ Leadership qualities: G_F_P_U_ Dependability: G_F_P_U_

Moral attitudes: G_F_P_U_ Consideration for others: G_F_P_U_ Financial dependability: G_F_P_U_

Honesty and integrity: G_F_P_U_ Response to authority: G_F_P_U_ Diligence as a worker: G_F_P_U_

Emotional Stability: G_F_P_U_ Teamwork Ability: G_F_P_U_ Spiritual influence on others: G_F_P_U_

To Your Knowledge, Does The Applicant:

Use tobacco?____ Use illegal/habit-forming drugs?________ Have a record of community disturbance?

Drink alcohol?_______ _____Gamble?____________ ____ Live an immoral life?__________

Applicant's Attitude Toward The Church and its Activities *(please tick as appropriate)*

Warm-hearted/Enthusiastic_______Tolerant/Passive_________Critical/Contemptuous______

Ministry *(please tick as appropriate)*

Is the applicant currently involved in active ministry? Yes________No________ Unknown___

Do you think the applicant has a definite call to the five-fold ministry? Yes____ No____ Unknown____

Do you recommend that the applicants be considered for Power Bible School enrollment? Yes___ No___ Unknown______

You may add comments that would be helpful in evaluating the applicant on a separate sheet of paper and attach to this form.

____

Referee's Signature