PART II HEALTH HISTORY

PLEASE PRINT – To be completed by the Applicant

Last Name:	First Name:		MI:
Address:	City:	SSN: _____-_____-_____	
State/Province/Region:	Postal/Zip Code:	Country:	
Cell Phone:	Birth Date: (mm/dd/yy)		Age:
Home Phone:	Email :	Gender: ▫ Male ▫ Female	

PHYSICAL EXAMINATION - To be completed by a Physician

Height:	Sinuses:	Nose and throat:
Weight:	Teeth:	Skin:
Heart:	Eyes	Blood Pressure:
Are there any thyroid or glandular difficulties?		
Are there any weaknesses or limitations?		
Do you consider the applicant's health adequate for intensive school work? ▫ Yes ▫ No		
Remarks:		

Please provide medical facility verification stamp in the box above.

PHYSICIAN INFORMATION:

Medical Facility:	Phone:
Email:	Website:

Physician's Signature

Date

Please return this form to: Christ For The Nations Institute * Attn: Enrollment Services Office* P. O. Box 769000 Dallas, TX 75376-9000