

**YOUTH WITH A MISSION**  
**SALEM, OREGON CAMPUS**  
**CHILDREN OF DESITNY**

**Entry Page**

Please Return to:  
**YWAM Salem**  
ATTN: Registrar  
7085 Battlecreek Rd. S.E.  
Salem, OR 97317 USA  
Phone (503) 364-3837 Fax (503) 365-0815  
E-mail registrar@ywamsalem.org

**IMPORTANT**  
**ATTACH RECENT**  
**PHOTO HERE**

Date of Application \_\_\_\_\_  
month / day / year

Beginning date of School \_\_\_\_\_  
month / day / year

**Identity:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Name Child Likes to be called: \_\_\_\_\_  
Street/ P.O. Box \_\_\_\_\_  
City \_\_\_\_\_  
State/Province \_\_\_\_\_ Postal Code \_\_\_\_\_ County \_\_\_\_\_  
Sex  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birthplace: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

**Child Information**

(Our commitment extends to further the spiritual, mental and emotional growth of your child. In order to assist us in meeting these needs, please help your child to answer following questions.)

1. How many years of school have you completed? \_\_\_\_\_ If not in school, have you completed preschool? \_\_\_\_\_
2. Favorite activities: \_\_\_\_\_  
\_\_\_\_\_
3. Least favorite activities: \_\_\_\_\_  
\_\_\_\_\_
4. Do you play an instrument  Yes  No If yes, can you bring it with you? \_\_\_\_\_
5. What Languages do you speak? \_\_\_\_\_
6. a.) Is English your mother tongue?  Yes  No  
b.) If no, how well do you speak it?  Fluently  Can manage  It's a struggle  Not at all
7. How do you feel about living in Oregon for three months? \_\_\_\_\_
8. What kind of relationship do you have with your family? \_\_\_\_\_  
\_\_\_\_\_
9. Write about your best friend. What is he or she like? What do you like to do together? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Have you ever moved before?  Yes  No How do you feel about leaving? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Child Information from Parents

In Order to Provide everything your child will need during the time with us, we will need further information about your child and his/her behavior and needs, please comment on the following with regards to your child.)

1. What would you like us to know about your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Does your child have any illness or had to undergo a surgery you think we should know about? \_\_\_\_\_  
\_\_\_\_\_
3. Does your child have any kind of allergies (food, medicine, etc...?) \_\_\_\_\_  
\_\_\_\_\_
4. Describe the personality and temperament of your child \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. How do they interact with adults? \_\_\_\_\_  
\_\_\_\_\_
6. Additional Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Parent's/ Guardian's Signature

Father's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mother's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# YOUTH WITH A MISSION SALEM, OREGON CAMPUS

## Confidential Health Form

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**E-mail registrar@ywamsalem.org**

### To the applicant: This information is treated as confidential.

Please print or type answer to ALL questions. As certain medical conditions may preclude acceptance, Physician's Examination must be completed by your physician or physician's assistant. Less inclusive done for other YWAM bases are not acceptable.

Name of School you are applying for \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_

Name \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_  
Last/Family Name First Middle Mo nth Day Year

Parents Name \_\_\_\_\_  
Mother/ Guardian Father/ Guardian

Preschool: Entry Date \_\_\_/\_\_\_/\_\_\_ Intermediate/middle: Entry Date \_\_\_/\_\_\_/\_\_\_  
 Elementary: Entry Date \_\_\_/\_\_\_/\_\_\_ High: Entry Date \_\_\_/\_\_\_/\_\_\_

### Medical Status

Please complete the following sections. Comment on all positive answers in the space on the following page or on a separate sheet of paper.

Area	Yes	No
Allergy ( Type)		
Asthma		
Vision Problems		
Cancer/ Leukemia		
Chronic Cough/ Wheezing		
Diabetes		

Area	Yes	No
Hearing Problems		
Heart Diseases		
Hemophilia		
Rheumatic Heart		
Sickle Cell Anemia		
Seizures		

If you answer yes to any of the previous questions, please explain : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Childhood record of immunizations

	Mo/day/Yr	Mo/D ay/ Yr	Mo/ Day/ Yr
Diphtheria			
Tetanus			
Pertussis			
Polio			
Rubella			
Measles			
Mumps			
Typhoid			
Hepatitis A & B			
Hepatitis C			

Date of last DT (Diphtheria/Tetanus) Booster. Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_ (must be within the last 5 years)

## Physician's Examination

### Tuberculosis Control

Must be within 6 month of the school.

	Date	Result	Examination Facility
Skin Test			
Chest X-ray			

\*if your skin test is positive , you must have a chest X-ray

### Dental Examination

	Date	Result	Examination Facility
Dental Check-up			

(Code: N- Normal; A-Abnormal; C-Corrected; R-Receiving Care)

Area	Code	Date	Date
Grade		/ /	/ /
Height		/ /	/ /
Weight		/ /	/ /
Blood Pressure		/ /	/ /
Hearing	R	/ /	/ /
	L	/ /	/ /
Eyes		/ /	/ /
Ears		/ /	/ /
Nose		/ /	/ /
Varicella Immunity Secondary to Disease		/ /	/ /

Area	Code	Date	Date
Throat		/ /	/ /
Teeth		/ /	/ /
Heart		/ /	/ /
Nose		/ /	/ /
Lungs		/ /	/ /
Abdomen		/ /	/ /
Nervous System		/ /	/ /
Skin		/ /	/ /
Scoliosis		/ /	/ /
Extremities		/ /	/ /
Nutrition		/ /	/ /

Significant Findings and Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reviewed Immunization Record

Completed PPD Screening

Physician's Name (print): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician's Signature: \_\_\_\_\_