Health History Form

As a counselor or support staff member you are **required** to bring this health form with you to camp. It requires a medical exam and must be completed and signed by a doctor. This health form does not affect your camp's decision to hire you or determine your acceptance to the CCUSA program. However, falsifying or failing to disclose information about your health may result in dismissal from the CCUSA program. **Remember certain immunizations are absolutely REQUIRED. Please see page 2 for this information.** If you have any questions or concerns about completing this form, contact your Country Director. If additional space is needed, please attach a separate sheet.

Note: Your camp might send you a copy of their Health History form specific to their camp. If so, please complete your camp's health history form and bring it with you to camp.

PERSONAL INFORMATION

Name ______________________________ (Last / First) Birth Date ________________ Sex: ☐ Male ☐ Female

Home Address ____ (Number & Street / City / Country / Postal Code)

Home Phone # ______________________________ Mobile Phone # ______________________________

Emergency Contact ____ Relationship ________________

Emergency Contact Home Phone # ______________________________ Work Phone # ______________________________

Alternate contact in case of emergency: Name ______________________________ Phone # ________________

Name of Current Physicial in Home Country ______________________________ Phone # ________________

HEALTH HISTORY—APPLICANT COMPLETE THIS SECTION

Check all that apply and give approximate date.

Illness	Date	Diseases	Date	Allergies
☐ Frequent ear infections	________	☐ Measles	________	☐ Poison Ivy/oak
☐ Heart defect/disease	________	☐ Chicken Pox	________	☐ Insect stings
☐ Convulsions	________	☐ German Measles	________	☐ Hay fever
☐ Diabetes	________	☐ Mumps	________	☐ Asthma
☐ Bleeding disorders	________	☐ Tuberculosis	________	☐ Penicillin
☐ Hypertension	________	☐ Hepatitis	________	☐ Other drugs (specify) ________
☐ Mononucleosis	________	☐ Bronchitis	________	☐ Food (specify) ________
☐ Sinus trouble	________			
☐ Migraine headaches	________			

I smoke: (check one): ☐ Regularly ☐ Occasionally ☐ Socially ☐ Never

I consume alcohol: (check one): ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

List surgeries or major illnesses you have had in the last 5 years (include dates): ______________________________

____

List chronic health concerns which might affect your ability to work. Please include any physical conditions requiring restriction(s) on participation in the camp program with a description of the restriction: ______________________________

____

What can your employer do to facilitate your performance? ______________________________

Have you ever been under a professional's care for emotional, psychological or learning difficulties? ☐ Yes ☐ No If yes, when and please describe ______________________________

Can you do the following without difficulty? Push ☐ YES ☐ NO Pull ☐ YES ☐ NO Walk ☐ YES ☐ NO Run ☐ YES ☐ NO
Bend ☐ YES ☐ NO Lift ☐ YES ☐ NO If you answered **No** to any of the above activities,

Please explain: ______________________________

MEDICATIONS BEING TAKEN—APPLICANT COMPLETE THIS SECTION

Please list ALL current medication(s) (including over-the-counter or nonprescription drugs). Bring enough medication to last the entire time at camp. Keep it in the original packaging that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications will be stored in the camp medical facility. Attach additional sheet for more medications.

☐ I take medications as stated below. ☐ I take NO medications on a routine basis.

Med #1 ______________________________ Dosage ________________ Specific times taken each day ________

Reason for taking ______________________________

Med #2 ______________________________ Dosage ________________ Specific times taken each day ________

Reason for taking ______________________________

DIETARY RESTRICTIONS—APPLICANT COMPLETE THIS SECTION

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs ☐ Does not eat poultry ☐ Does not eat seafood

☐ Lactose Intolerant ☐ Gluten Free ☐ Other dietary restrictions ______________________________

GENERAL QUESTIONS—APPLICANT COMPLETE THIS SECTION

The following questions must be answered truthfully, and to the best of your knowledge.

	Question		
1.	Had any recent injury, illness or infectious disease?	☐ YES	☐ NO
2.	Ever had a chronic or recurring illness?	☐ YES	☐ NO
3.	Ever been hospitalized?	☐ YES	☐ NO
4.	Ever had surgery?	☐ YES	☐ NO
5.	Have frequent headaches?	☐ YES	☐ NO
6.	Ever had a head injury?	☐ YES	☐ NO
7.	Ever been knocked unconscious?	☐ YES	☐ NO
8.	Wear glasses, contacts?	☐ YES	☐ NO
9.	Ever had frequent ear infections?	☐ YES	☐ NO
10.	Ever passed out during or after exercise?	☐ YES	☐ NO
11.	Ever had seizures?	☐ YES	☐ NO
12.	Ever had chest pain during or after exercise?	☐ YES	☐ NO
13.	Ever had high blood pressure?	☐ YES	☐ NO
14.	Ever had back problems?	☐ YES	☐ NO
15.	Ever had problems with joints (e.g. knees, ankles)?	☐ YES	☐ NO
16.	Have any skin problems (itching, rashes, acne)?	☐ YES	☐ NO
17.	Have diabetes?	☐ YES	☐ NO
18.	Have asthma?	☐ YES	☐ NO
19.	Had mononucleosis in the past 12 months?	☐ YES	☐ NO
20.	Had problems with diarrhea/constipation?	☐ YES	☐ NO
21.	Have problems with sleepwalking?	☐ YES	☐ NO
22.	If female, have an abnormal menstrual history?	☐ YES	☐ NO
23.	Have a diagnosed eating disorder?	☐ YES	☐ NO
24.	Ever had emotional and/or mental difficulties?	☐ YES	☐ NO
25.	If YES, did you seek professional help?	☐ YES	☐ NO
26.	If YES, did you receive medication?	☐ YES	☐ NO
27.	Have you ever tested positive for HIV?	☐ YES	☐ NO

Please explain any **Yes** answers, noting the question number(s) above before your response. **ALSO CONTACT YOUR CCUSA REPRESENTATIVE IF YOU ANSWERED YES TO ANY OF THE ABOVE.**

____

____

The information contain in the Health History Form is valid with regard to my current health status. I understand and agree that if this information is incorrect or I am not able to follow the health guidelines set by my camp, I risk dismissal from the CCUSA program. If a change in my health status occurs, I agree to notify the camp in writing of that change prior to leaving for the USA. I hereby give permission for emergency medical care to take place should it be necessary. I HEREBY CERTIFY that all statements containing in the Heath History Form are true and correct to the best of my knowledge, and further, I AUTHORIZE THE INSURANCE COMPANY or any party the company authorizes to obtain, or release any information acquired in the course of my examination or treatment.

Applicant's signature ____________________________ Date____________________

IMMUNIZATION HISTORY—MUST BE COMPLETED WITH A LICENSED PHYSICIAN

Please record the month and year of immunizations.

Vaccines	Immunization Date	Vaccines	Immunization Date	Vaccines	Immunization Date
DPT series* (Diphtheria, Pertussis, Tetanus)	________	Tetanus	________	Polio*	________
MMR* (Mumps, Measles, Rubella)	________	Small Pox	________	Typhoid	________
Hepatitis B	________				

Required Immunizations (if expired new immunizations MUST be taken)

Tuberculin test given: (date) ____________________ The Tuberculin test is required prior to your arrival at camp. Please contact your Camp Director if this test is not offered in your country. If you test positive for Tuberculin you are required to get a chest x-ray and bring it to camp along with your health history form. Chest x-rays administered in the U.S. are likely to be at the participant's expense.

MEDICAL EXAMINATION—MUST BE COMPLETED BY A LICENSED PHYSICIAN

Note to examining physician: This person has applied for a program in the United States as a supervisor/leader of children. This program involves rigorous physical activity and long working hours. Your exam should be directed to the person's fitness to engage in such a program.

Height______________ Weight ______________ Does this person wear glasses or contact lenses? ☐ YES ☐ NO

Please use the following code when completing your examination: S = Satisfactory X = Not Satisfactory O = Not Examined

_____ Eyes _____Heart ____ Lungs _____Ears ______Spine _____ Extremities

_____ Nose _____Blood Pressure ____ Teeth _____Skin ______Abdomen _____ Throat

Is this person on any medications that she/he will need to bring to the United States? (Please describe): ____________________

____

Please rate the **overall** muscular skeletal condition of this person: ____________________

Back: ________________ Knees: ________________ Ankles: ________________

I have examined the above CCUSA applicant and have reviewed her/his health history. It is my opinion that she/he: (circle) **IS** **IS NOT** physically able to engage in the rigors of camp.

Licensed Examining Physician's Signature ________________________ Date ________________

Physician's Name (please print) ________________________ Phone ________________

Address____

Number & Street City Country Postal Code