



Camp Counselors USA - 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. 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 have your physician complete the camp's health history form (instead of the CCUSA form) and send a copy to CCUSA and your camp and bring the original to camp with you.

PERSONAL INFORMATION

Last Name	First Name	Birth Date	Sex:	Male	Female
Home Address					
Number & Street		City	Postal Code	Country	
Home Phone #		Mobile Phone			
Emergency Contact Name			Relationship		
Home Phone		Mobile	Work Phone		
Alternate contact in case of emergency: Name			Phone		
Name of Physician 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/Sumac			
Heart defect/disease		Chicken Pox		Insect stings			
Seizures		German Measles		Hay fever			
Diabetes		Mumps		Asthma			
Bleeding disorders		Tuberculosis		Penicillin			
Hypertension		Hepatitis		Other drugs (specify)			
Mononucleosis		Bronchitis		Food (specify)			
Sinus trouble		I smoke: (check one):	Regularly	Occasionally	Socially	Never	
Migraine headaches		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 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 medications including over-the-counter, non-prescriptions, vitamins and supplements. 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.

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

Please explain any **Yes** answers, noting the question number(s) above before your response. **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 contained 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 BY A REGISTERED MEDICAL PROFESSIONAL

Please record the month and year of immunizations.

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

**Required Immunizations (if expired new immunizations MUST be taken)*

Tuberculin test given: The Tuberculin test is required prior to your arrival at camp. If this test is not offered in your country, please contact CCUSA for instructions. If your test results are positive, please contact CCUSA immediately. A positive test result can affect the ability to obtain a visa for the USA and would thus affect your participation on the CCUSA program.

MEDICAL EXAMINATION—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Note to examining physician: This program involves rigorous physical activity and long working hours which can be taxing. Your exam should be directed to the person's mental and physical 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: (check)	IS	IS NOT
physically able to engage in the rigors of camp.		
Licensed Examining Physician's Signature	Date	
Physician's Name (please print) Name	Phone	
Address		
Number & Street	City	Postal Code Country

