Health History Form

CCUSA

The participant must complete all sections of this form. It must be completed in English as a fillable PDF or neatly hand written. Please provide as much detail as possible. Please upload this form to your Footprints account and take the original copy with you to camp. Falsifying or failing to disclose information about your health may result in dismissal from the CCUSA program. Remember certain immunizations are REQUIRED. If you have any questions or concerns about this form, contact your local CCUSA office. If additional space is needed, please attach a separate sheet.

PERSONAL INFORMATION

Last Name _____ First Name _____ Birth Date _____ Gender: ☐ 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 _____

Address of physician _____ (Number & Street) _____ (City) _____ (Postal Code) _____ (Country)

HEALTH HISTORY

Check all that apply and give approximate date.

Illness	Date	Diseases	Date
☐ Frequent ear infections		☐ Measles*	
☐ Heart defect/disease		☐ Chicken Pox*	
☐ Seizures		☐ Whooping Cough	
☐ Diabetes		☐ Mumps*	
☐ Bleeding disorders		☐ Tuberculosis*	
☐ Hypertension		☐ Hepatitis	
☐ Mononucleosis		☐ Bronchitis	
☐ Sinus trouble		☐ Lyme Disease	
☐ COVID-19†		☐ Migraine headaches	

Allergies

☐ Poison Ivy/Oak/Sumac ☐ Insect stings
☐ Hay fever ☐ Asthma (Moderate/Severe)
☐ Penicillin
☐ Other drugs (specify) _____
☐ Food (specify) _____

Do you require an epipen or medication for allergies?
☐ Yes ☐ No If Yes, please list

*If you have not been immunized for this, then please speak to your Doctor/Medical Practitioner to ensure you obtain these vaccinations/inoculations prior to arrival.
†Many US camps will prefer their staff to have an approved COVID-19 vaccination and your entry into the country may be reliant on proof of vaccination.

I smoke: ☐ Regularly ☐ Occasionally ☐ Socially ☐ Never I consume alcohol: ☐ 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 on the program with a description of the restriction:

If you have listed any chronic health concerns, what can your employer do to facilitate your performance?

Have you ever been under a professionals care for emotional, psychological or learning difficulties? ☐ Yes ☐ No If yes, when and describe.

Can you do the following, without difficulty, for an extended amount of time? Push: ☐ Yes ☐ No Pull: ☐ Yes ☐ No Walk: ☐ Yes ☐ No
Run: ☐ Yes ☐ No Bend: ☐ Yes ☐ No Lift: ☐ Yes ☐ No If **No**, please explain: _____
Can you physically and emotionally support children and yourself for the summer? ☐ Yes ☐ No

CURRENT MEDICATIONS (IF ANY)

Please list ALL current medications including over-the-counter and prescriptions. Bring enough medication to last your entire trip overseas. 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. Attach additional sheet for more medications if needed.

☐ 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 _____
Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

DIETARY INFORMATION

☐ Vegetarian ☐ Vegan ☐ Lactose Intolerant ☐ Gluten Free ☐ Coeliac
☐ Other dietary restrictions/food allergies _____

GENERAL QUESTIONS

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
2. Have 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, psoriasis)? ☐ 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. Ever had a diagnosed eating disorder? ☐ Yes ☐ No
23. Ever had emotional and/or mental difficulties? ☐ Yes ☐ No
    If YES, did you seek professional help? ☐ Yes ☐ No
    If YES, did you receive medication? ☐ Yes ☐ No
24. Have you ever tested positive for HIV? ☐ Yes ☐ No
25. Have you ever tested positive for Tuberculosis? ☐ Yes ☐ No

Please explain any **YES** answers, noting the question number(s) above before your response. Use an additional sheet if more space is required.
CONTACT YOUR CCUSA REPRESENTATIVE IF YOU ANSWERED YES TO ANY OF THE ABOVE.

IMMUNIZATION HISTORY

Enter the month/year of immunizations and booster date (if applicable). If multiple doses, list the date of each dose. If unsure you have had the mandatory immunizations a "Titer Test" must be taken and results sent to CCUSA before departure.

Vaccines	Dose 1	Dose 2	Booster	Vaccines	Dose 1	Dose 2	Booster
DPT series* (Diphtheria, Pertussis, Tetanus)				Varicella (Chicken Pox) **			
MMR* (Mumps, Measles, Rubella)				Small Pox			
Hepatitis A				Typhoid			
Hepatitis B				IPV* (Polio)			
COVID-19†				Name of COVID-19 Vaccine			

**Mandatory Immunizations (if expired new immunizations MUST be taken)* ***Only required if not immune*
†International travel and employment may be reliant on proof of vaccination. Confirm with your local CCUSA office which COVID vaccine is approved for your program.

Have you ever been tested for Tuberculosis (TB)? Yes ☐ No ☐ If Yes - Date:
If No - employer may require this prior to arrival and must discuss this directly with employer.

I understand and agree that if this information is incorrect or I am not able to follow the health guidelines set by my employer, I risk dismissal from the CCUSA program.

If a change in my health status occurs, I agree to notify CCUSA and the employer I am placed at in writing of that change immediately and prior to leaving my home country.

I hereby give permission for emergency medical care to take place should it be necessary.

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.

I give permission for CCUSA to contact my doctor for any additional information. If submitting this form electronically (emailing form) check the box below as an alternative to signing.

I hereby certify that all information and statements contained in this Heath History Form are valid, true and correct to the best of my knowledge, in regards to my current and previous health status.

☐ Applicant's signature Date