Pre-Existing Medical Condition Questionnaire & Health History Form

CCUSA

The participant and their Doctor 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. 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 - APPLICANT COMPLETE THIS SECTION

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 _____

HEALTH HISTORY—APPLICANT COMPLETE THIS SECTION

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.

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

MEDICATIONS BEING TAKEN—APPLICANT COMPLETE THIS SECTION

Please list ALL current medications including over-the-counter, prescriptions, vitamins and supplements. 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 RESTRICTIONS—APPLICANT COMPLETE THIS SECTION

☐ Vegetarian ☐ Vegan ☐ Lactose Intolerant ☐ Gluten Free

☐ Other dietary restrictions/food allergies

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, psoriasis)?	☐ 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.	Ever had a diagnosed eating disorder?	☐ Yes ☐ No
9.	Ever had frequent ear infections?	☐ Yes ☐ No	23.	Ever had emotional and/or mental difficulties?	☐ Yes ☐ No
10.	Ever passed out during or after exercise?	☐ Yes ☐ No		If YES, did you seek professional help?	☐ Yes ☐ No
11.	Ever had seizures?	☐ Yes ☐ No		If YES, did you receive medication?	☐ Yes ☐ No
12.	Ever had chest pain during or after exercise?	☐ Yes ☐ No	24.	Have you ever tested positive for HIV?	☐ Yes ☐ No
13.	Ever had high blood pressure?	☐ Yes ☐ No	25.	Have you ever tested positive for Tuberculosis?	☐ Yes ☐ No
14.	Ever had back problems?	☐ 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.

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. 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. I agree to purchase my own supplemental insurance to cover my pre-existing medical condition while on this program. If submitting this form electronically (emailing form) check the box below as an alternative to signing.

☐ Applicant's signature Date

GENERAL QUESTIONS—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Patient Name Birth Date Patient Since

Please name and describe the patient's pre-existing medical condition and treatment:

How long has the patient had this condition?

What medication(s), if any, has the patient taken for this condition? Please list dates (month and year) to and from. Please make note of dosage, how often it needs to be taken, and the dates the patient was required to take the medication.

How often do you need to see the patient for this medical condition?

Has the patient been hospitalized for this condition in the past 5 years? If yes, when and for how long?

Have you provided your patient information on how time zone changes and new external stresses can alter or affect his/her medication doses and timing or create unexpected medical conditions. ☐ Yes ☐ No (if No please explain)

This program involves rigorous physical activity, long working hours, extreme weather conditions and potential stressful situations. Your assessment should be directed to the person's pre-existing mental and / or physical fitness to engage in such a program. Depending on their employer and location of the job, your patient might not have immediate access to emergency care. There is no liability associated with your recommendation of suitability. Your patient will need to find and purchase their own medical insurance at their own cost to cover their pre-existing condition. If they have a relapse, they will not have the support immediately on hand from family, friends or yourself.

Based on this statement, as their Licensed Physician, do you believe that it is in your patient's best interest to:

Participate in this program? ☐ Yes ☐ No (if No please explain)

Travel by themselves for 3-12 months and oversee their own medication and treatment without the input of a physician and/or parents?

☐ Yes ☐ No (if No please explain)

Leave their family, friends and your care to work overseas? ☐ Yes ☐ No (if No please explain)

Additional Comments (Please feel free to include additional pages if necessary):

IMMUNIZATION HISTORY—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

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

Vaccines	Immunization	Booster(s)	Vaccines	Immunization	Booster(s)
DPT series* (Diphtheria, Pertussis, Tetanus)			Varicella (Chicken Pox) **		
MMR* (Mumps, Measles, Rubella)			Small Pox		
Hepatitis A			Typhoid		
Hepatitis B			IPV* (Polio)		
COVID-19					

**Mandatory Immunizations (if expired new immunizations MUST be taken)* **Only required if not immune

Has this patient ever been tested for Tuberculosis (TB)? ☐ Yes ☐ No If Yes - Date:

If No - Patient must understand that their employer may require this prior to arrival and must discuss this directly with their employer.

MEDICAL ASSESSMENT —MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Note to physician: This program involves rigorous physical activity, long working hours, extreme weather conditions and potential stressful situations. Your assessment should be directed to the person's mental and physical fitness to engage in such a program. There is no liability associated with your recommendation of suitability.

Height Weight

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 take with them overseas? (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 the program. (Please Note: There is no liability associated with your recommendation of suitability.)

If submitting this form electronically (emailing form) check the box below as an alternative to signing.

☐ Licensed Examining Physician's Signature Date

Physician's Name (please print) Phone

Address
Number & Street City Postal Code Country