



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 _____ Birth Date _____ Sex: Male Female
Last First
 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 Physical in Home Country _____ Phone # _____

HEALTH HISTORY—APPLICANT COMPLETE THIS SECTION

Check all that apply and give approximate date.

Illness	Date	Diseases	Date	Allergies
<input type="checkbox"/> Frequent ear infections	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Poison Ivy/oak
<input type="checkbox"/> Heart defect/disease	_____	<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Insect stings
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> German Measles	_____	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Other drugs (specify) _____
<input type="checkbox"/> Mononucleosis	_____	<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Food (specify) _____
<input type="checkbox"/> Sinus trouble	_____	I smoke: (check one): <input type="checkbox"/> Regularly		<input type="checkbox"/> Occasionally <input type="checkbox"/> Socially <input type="checkbox"/> Never
<input type="checkbox"/> Migraine headaches	_____	I consume alcohol: (check one): <input type="checkbox"/> Daily		<input type="checkbox"/> Weekly <input type="checkbox"/> Seldom <input type="checkbox"/> 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 _____



