Support Staff 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. You agree to provide as much detail as possible and if we are not able to read your writing it will be returned and will need to be completed again. You are required to upload all 3 pages through your CCUSA Footprints site prior to your possible acceptance to the program. You will need to take the original with you to the camp you are placed at. Falsifying or failing to disclose information about your health may result in dismissal from the CCUSA program. Remember certain immunizations are absolutely REQUIRED. If you have any questions or concerns about completing 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 _____ 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 Physical 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:

If you have listed any chronic health concerns, what could 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 CCUSA and the camp I am placed at 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. 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.

☐ Applicant's signature _____ Date _____

GENERAL QUESTIONS—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Patient Name _____ Birth Date _____ Patient Since _____

Please review the following job description before commenting on the questions below:
Participants will work in the kitchen or laundry, in the office or doing general maintenance work. The work is demanding and includes physical labor such as lifting, hauling and working outside during summer months. Some jobs require being on your feet most of the day. Support staff work up to 10 hours a day. Typical breaks include 2-3 hours per day and 1 day off per week.

Please name and describe the medical condition:

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?

As stated, camp can be very tiring and mentally and physically draining to your patient. As Support Staff they will be working 10 hours a day, 6 days a week for 9-12 full weeks. There will be very little down time. Camps do not have major medical centres at their facility, so no specific medical support at camp if someone has relapse. Yes camps have nurses at camp but it is not a hospital nor a medical facility. Participants will also need to find and purchase Pre-existing Medical insurance at their own cost to cover their pre-existing condition and if they have a relapse understand that they will not have the support overseas during this time of crisis.

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)

Complete suuport staff duties and take part in all camp activities? ☐ Yes ☐ No (if No please explain)

Travel by themselves for almost 3 months? ☐ Yes ☐ No (if No please explain)

Leave their family, friends and your care to work at a summer camp? ☐ 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

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: ☐ 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.

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