NYQUEST TRAINING PLACEMENT

Health History Form

As a counsellor or support staff you are required to send a completed copy of this form to NYQUEST or your home country recruiter by May 1st of the current placement year. You must also bring a copy of this form to your camp.
In order to complete this form, you should print out a copy and fill it in neatly by hand with a black or blue pen. You should fill out the first page and a half on your own. The second half of the second page must be filled in and signed by a licensed physician/doctor.
Falsifying or failing to disclose information about your health may result in dismissal from the program. 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 home country office or NYQUEST. 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 the camp's form requires you to fill out the form with a doctor then you can use the camp form or this form. If the camp's form does not require a screening by a doctor then you must use this form.

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 # ______________________

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	
☐ Heart defect/disease	______	☐ Chicken Pox	______	☐ Insect stings	
☐ Convulsions	______	☐ German Measles	______	☐ Hay fever	
☐ Diabetes	______	☐ Mumps	______	☐ Asthma	
☐ Bleeding disorders	______	☐ Tuberculosis	______	☐ Penicillin	
☐ Hypertension	______	☐ Hepatitis	______	☐ Other drugs (specify)	______
☐ Mononucleosis	______	☐ Bronchitis	______	☐ Food (specify)	______
☐ Sinus trouble	______				
☐ Migraine headaches	______				

I smoke: (check one): ☐ Regularly ☐ Occasionally ☐ Socially ☐ Never

I consume alcohol: (check one): ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

List surgeries or major illnesses you have had in the last 18 months (include dates): ______________________

List chronic health concerns which might affect your ability to work: ______________________

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 acitivies,

please explain: ______________________

MEDICATIONS BEING TAKEN—APPLICANT COMPLETE THIS SECTION

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. 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

☐ Does not eat dairy products ☐ Other dietary restrictions ______________________

Name: ____

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
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 sustained an injury from a vehicle accident? ☐ YES ☐ NO
16. Ever had problems with joints (e.g. knees, ankles)? ☐ YES ☐ NO
17. Have any skin problems (itching, rashes)? ☐ YES ☐ NO
18. Have diabetes? ☐ YES ☐ NO
19. Have asthma? ☐ YES ☐ NO
20. Had mononucleosis in the past 12 months? ☐ YES ☐ NO
21. Had problems with diarrhea/constipation? ☐ YES ☐ NO
22. Have problems with sleepwalking? ☐ YES ☐ NO
23. If female, have an abnormal menstrual history? ☐ YES ☐ NO
24. Have a history of bed-wetting? ☐ YES ☐ NO
25. Ever had a diagnosed eating disorder? ☐ YES ☐ NO
26. Ever had emotional difficulties such as depression for which professional help or medication was sought? ☐ YES ☐ NO
27. Have you ever tested positive for HIV or AIDS? ☐ YES ☐ NO

Please explain any YES answers, noting the question number(s) above before your response.

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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 NYQUEST program. If a change in my health status occurs, I agree to notify the camp in writing of that change prior to leaving for Canada. I hereby give permission for emergency medical care to take place should it be necessary. I HEREBY CERTIFY that all statements containing in the Health 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 WITH A LICENSED PHYSICIAN

Please record the month and year of immunizations.

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

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

MEDICAL EXAMINATION—MUST BE COMPLETED BY A LICENSED PHYSICIAN

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

_____ Urinalysis _____ Blood Pressure _____ Teeth _____ Skin _____ Abdomen _____ Throat

Is this person on any medications that she/he will need to bring to Canada? (please describe): ____________________

____

Please rate the overall muscular skeletal condition of this person: ____________________

Back: ______________ Knees: ______________ Ankles: ______________

Has he/she suffered from any significant mental/emotional health difficulties, e.g. depression, eating disorders, psychological or learning difficulties? _________

____

I have examined the above individual and have reviewed her/his health history.
In my opinion she/he: (circle) IS IS NOT physically and emotionally able to work effectively as a camp staff member

Licensed Examining Physician's Signature ______________________________ Date ____________________

Physician's Name (please print) ______________________________ Phone ____________________

Address ____
Number & Street City Country Postal Code