



Pre-existing Medical Condition Questionnaire

Participant's Doctor must complete all sections of this form.
Please write legibly or type answers below and provide as much detail as possible.

Patient Name _____ Birth Date: _____

Doctor Name _____ Patient Since: _____

Dear Medical Practitioner,

Please review the following job description (s) before commenting on the questions below:

Counselor: As a counselor, the participant will be required to teach and lead children aged 5-17 yrs of age. Many of the tasks are activity based and require physical and mental endurance. Counselors live in cabins with children and often spend 24 hours/day, 6 days/week for 9 weeks with them. Typical breaks include 1-2 hours off per day and 1 day off per week.

Support Staff: 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.

Thank you!

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 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, where and for how long?

From a medical standpoint, do you feel this patient is physically, emotionally and/or mentally prepared for the duties they will be required to perform at camp (see box above for description of duties)?

Do you foresee any problems for the patient participating in camp activities?

Additional Comments:

Doctor's Signature: _____ Date: _____

Address: _____

Telephone Number: _____

I give permission for CCUSA to contact my doctor for any additional information.

Participant's Signature: _____ Date: _____

Please feel free to include additional pages if necessary

