Health History Form

CCUSA™

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 Buller (Last) Zoë (First) Birth Date 06 Oct 1988 Sex: ☐ Male ☑ Female

Home Address 25, Sladelands Drive (Number & Street) Chellaston (City) Derby (Country) UK DE73 6QB (Postal Code)

Home Phone # _____ Mobile Phone # 07725 894636

Emergency Contact Peter Buller Relationship Father

Emergency Contact Home Phone # 01423 712162 07734 144 551 Work Phone # 01423 711309

Alternate contact in case of emergency: Name _____ Phone # _____

Name of Current Physicial 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
☐ 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 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 _____

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. Ever had 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	25. If YES, did you seek professional help?	☐ YES ☐ NO
12. Ever had chest pain during or after exercise?	☐ YES ☑ NO	26. If YES, did you receive medication?	☐ YES ☐ NO
13. Ever had high blood pressure?	☐ YES ☑ NO	27. Have you ever tested positive for HIV?	☐ YES ☑ NO
14. Ever had back problems?	☐ YES ☑ NO		

Please explain any **Yes** answers, noting the question number(s) above before your response. **ALSO CONTACT YOUR CCUSA REPRESENTATIVE IF YOU ANSWERED YES TO ANY OF THE ABOVE.**

4 - Appendictus when I was 11. Laproscopy in 2009 ish.
22 - Endometriosis

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 the camp 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 containing 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.

Applicant's signature EBuller 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)	1989	Tetanus	2003	Polio*	2003
MMR* (Mumps, Measles, Rubella)	1990	Small Pox		Typhoid	
Hepatitis B					

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

Tuberculin test given: (date) BCG 2003 The Tuberculin test is required prior to your arrival at camp. Please contact your Camp Director if this test is not offered in your country. If you test positive for Tuberculin you are required to get a chest x-ray and bring it to camp along with your health history form. Chest x-rays administered in the U.S. are likely to be at the participant's expense.

MEDICAL EXAMINATION—MUST BE COMPLETED BY A LICENSED PHYSICIAN

Note to examining physician: This person has applied for a program in the United States as a supervisor/leader of children. This program involves rigorous physical activity and long working hours. Your exam should be directed to the person's fitness to engage in such a program.

Height 1.79 m Weight 68 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

O Eyes	S Heart	S Lungs	S Ears	S Spine	S Extremities
S Nose	S Blood Pressure	S Teeth	S Skin	S Abdomen	S Throat

Is this person on any medications that she/~~he~~ will need to bring to the United States? (Please describe): NO PRESCRIBED MEDICATIONS

Please rate the **overall** muscular skeletal condition of this person: GOOD

Back: S Knees: S Ankles: S

I have examined the above CCUSA applicant and have reviewed her/his health history. It is my opinion that she/he: (circle) **IS** ~~**IS NOT**~~ physically able to engage in the rigors of camp.

Licensed Examining Physician's Signature P. DAS Date 17.6.14

Physician's Name (please print) PHILIP DAS Phone

Address MELBOURNE MEDICAL CENTRE, PENN LANE, MELBOURNE UK DE73 8RB
Number & Street City Country Postal Code

MELBOURNE & CHELLASTON MEDICAL PRACTICE
Melbourne Medical Centre,
Penn Lane,
Melbourne,
Derby, DE73 8EF
Telephone: (01332) 862124