



**YMCA
OF GREATER NEW YORK**

We build strong kids, strong families,
strong communities

INTERNATIONAL CAMP COUNSELOR PROGRAM

2011 Health History

Participant Section:

Name:

Male: Female: Age: Date Of Birth: (Month / Day / Year)
M D Y

Address:

Telephone: (Country Code / City Code / Number)

IN AN EMERGENCY PLEASE NOTIFY:

Name:

Address:

Telephone: (Country Code / City Code / Number)

Physician Section:

TO THE PHYSICIAN: This person will serve up to four months in the USA as a leader in summer camp for children/adults or as support staff in the kitchen, office, or maintenance department of a summer recreational facility. Your careful examination and written recommendations will encourage physical wellness and safe participation in strenuous activities.

Health History:

Check each appropriate box and give approximate dates.

Immunization History:

Please give approximate dates. Required immunizations are determined by each U.S. state. Participant should ask U.S. site director which are required.

	YES	NO	DATE
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

	DATE
Tuberculosis (TB)	<input type="text"/>
Polio	<input type="text"/>
Tetanus	<input type="text"/>
Measles	<input type="text"/>
Typhoid	<input type="text"/>
Tuberculin Test	<input type="text"/>
Diphtheria	<input type="text"/>
Mumps Measles	<input type="text"/>

Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Rubella (German Measles)	<input type="text"/>
Other	<input type="text"/>
_____	<input type="text"/>
_____	<input type="text"/>
_____	<input type="text"/>

Health History Questions:

Does the participant have any allergies? (Examples: Hay Fever, Poison Ivy, Insect Stings, Penicillin, Other Drugs, Foods or Animals)	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>
Has the participant had any operations?	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>
Does the participant suffer from any Chronic or recurring illnesses?	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>
Does the participant currently have a medical condition requiring the regular intake of medication?	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>
Does the participant have any history of emotional or mental disturbances?	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>
Has the participant ever suffered from an eating disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	DETAILS <input type="text"/>

Current Health status:

	Satisfactory	Unsatisfactory	Not Examined		Satisfactory	Unsatisfactory	Not Examined		Satisfactory	Unsatisfactory	Not Examined
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

General Appraisal:

Special Diet (vegetarian, etc)

Are there any restrictions on: Swimming/Diving YES NO Camping/Hiking YES NO

Can the participant participate in strenuous Activities YES NO Other _____

Does the participant smoke? YES NO

Would the participant be prepared NOT to smoke at camp? YES NO

Does the participant have any visible tattoos or body piercing? YES NO

DETAILS

How often does participant consume Alcohol? Never Daily Weekly Monthly
Special Occasions only

(For Females) Is menstrual history normal? YES NO DETAILS

(For Females) Are you pregnant? YES NO

FOR PHYSICIAN: (I have examined this person and have reviewed the health history. It is my opinion that this person is physically able to engage in strenuous activities, except as noted above).

Signature: _____ Date: _____

Telephone: _____ Address: _____

FOR PARENTS / GUARDIANS OF PARTICIPANT IF UNDER 21: (In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the U.S. site director to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child as named above.

Signature: _____ Date: _____

PLEASE NOTE: Each ICCP participant has been provided with an illness and accident Insurance claim form. This form may be filled out and taken to the doctor's office and/or hospital and/or sent directly to the Insurance Company along with all bills pertaining to the illness or injury. Accident and Health insurance is only provided while the participant is on the ICCP Program. Please note: Pre-existing conditions will not be covered.

**THERE IS A \$100 CO-PAY PER VISIT UNLESS ACCIDENT OR SICKNESS PERTAINS TO THE INITIAL VISIT.
If medical history changes you must submit a new health history form to your local ICCP Overseas Partner.**