INTERNATIONAL CAMP COUNSELOR PROGRAM

PLEASE COMPLETE PARTICIPANT SECTION THEN PRINT AND HAVE COMPLETED

International YMCA
We build strong kids, strong families, strong communities.

2007 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.

	YES	NO	DATE
Asthma	☐	☐	
Malaria	☐	☐	
Chicken Pox	☐	☐	
Convulsions	☐	☐	
Diabetes	☐	☐	
Meningitis	☐	☐	
Fainting	☐	☐	
Heart Trouble	☐	☐	
Measles	☐	☐	
Mumps	☐	☐	
German Measles	☐	☐	
Rheumatic Fever	☐	☐	
Hepatitis	☐	☐	
Seizures	☐	☐	

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.

	DATE
Tuberculosis (TB)	
Polio	
Tetanus	
Measles	
Typhoid	
Tuberculin Test	
Diphtheria	
Mumps Measles	
Rubella (German Measles)	
Other	
_____	
_____	
_____	

Health History Questions:

Does the participant have any allergies? YES ☐ NO ☐ DETAILS
(Examples: Hay Fever, Poison Ivy, Insect Stings, Penicillin, Other Drugs, Foods or Animals)

Has the participant had any operations? YES ☐ NO ☐ DETAILS

Does the participant suffer from any Chronic or recurring illnesses? YES ☐ NO ☐ DETAILS

Does the Participant currently have a medical condition requiring the regular intake of medication? YES ☐ NO ☐ DETAILS

Does the participant have any history of emotional or mental disturbances? YES ☐ NO ☐ DETAILS

Has the participant ever suffered from an eating disorder? YES ☐ NO ☐ DETAILS

Current Health status:

	Satisfactory	Unsatisfactory	Not Examined		Satisfactory	Unsatisfactory	Not Examined		Satisfactory	Unsatisfactory	Not Examined
Eyes	☐	☐	☐	Genitalia	☐	☐	☐	Abdomen	☐	☐	☐
Ears	☐	☐	☐	Lungs	☐	☐	☐	Extremities	☐	☐	☐
Nose	☐	☐	☐	Heart	☐	☐	☐	Posture (Spine)	☐	☐	☐
Throat	☐	☐	☐	Hernia	☐	☐	☐	Skin	☐	☐	☐

General Appraisal: _____

Special Diet (vegetarian, etc) _____

Any restrictions on: Swimming/Diving YES ☐ NO ☐ Camping/Hiking YES ☐ NO ☐

Strenuous Activities YES ☐ NO ☐ Other_____ YES ☐ NO ☐

Does participant smoke? YES ☐ NO ☐

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

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 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.

THERE IS A $10 CO-PAY PER VISIT UNLESS ACCIDENT OR SICKNESS PERTAINS TO THE INITIAL VISIT.