



Health History Form

As a counsellor support staff you are required to send a completed copy of this form to NYQUEST or your home country recruiter by JUNE 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/nurse. 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
<input type="checkbox"/> Frequent ear infections	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Poison Ivy/oak
<input type="checkbox"/> Heart defect/disease	_____	<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Insect stings
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> German Measles	_____	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Other drugs (specify) _____
<input type="checkbox"/> Mononucleosis	_____	<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Food (specify) _____
<input type="checkbox"/> Sinus trouble	_____	I smoke: (check one):	<input type="checkbox"/> Regularly	<input type="checkbox"/> Occasionally <input type="checkbox"/> Socially <input type="checkbox"/> Never
<input type="checkbox"/> Migraine headaches	_____	I consume alcohol: (check one):	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly <input type="checkbox"/> Seldom <input type="checkbox"/> 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 activities, 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? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 15. Ever sustained an injury from a vehicle accident? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Have a chronic or recurring illness? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 16. Ever had problems with joints (e.g. knees, ankles)? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Ever been hospitalized? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 17. Have diabetes? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Ever had surgery? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 18. Have asthma? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. Have frequent headaches? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 19. Had mononucleosis in the past 12 months? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. Ever had a head injury? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 20. Have problems with sleepwalking? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 21. If female, have an abnormal menstrual history? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8. Wear glasses, contacts? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 22. Have a history of bed-wetting? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 23. Ever had a diagnosed eating disorder? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 24. Have you ever had thoughts of harming yourself or others? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 11. Ever had seizures? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 25. Has anti-depressant medication ever been prescribed for you or have you ever taken anti-depressant medication or sought medical help for depression or other any other emotional or mental health related challenge? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 12. Ever had chest pain during or after exercise? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 26. Have you ever tested positive for HIV or AIDS? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 13. Ever had high blood pressure? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. Ever had back problems? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

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

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

PLEASE NOTE, A COMPREHENSIVE MEDICAL EXAMINATION IS NOT REQUIRED FOR THE PURPOSES OF PROGRAM PARTICIPATION

Height _____ Weight _____ Does this person wear glasses or contact lenses? YES NO

Does this person have any physical limitations/conditions that may effect their ability to participation in camp activities or work with children? (please describe):

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

Back: _____ Knees: _____ Ankles: _____

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

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/or 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

