Health History Form

As a counsellor or support staff you are required to send a completed copy of this form to NYQUEST or your home country recruiter by May 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.
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
☐ 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	_____	I smoke: (check one):	☐ Regularly	☐ Occasionally ☐ Socially ☐ Never
☐ Migraine headaches	_____	I consume alcohol: (check one):	☐ Daily	☐ Weekly ☐ Seldom ☐ 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 acitivies, 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?	☐ YES ☐ NO	15.	Ever sustained an injury from a vehicle accident?	☐ YES ☐ NO
2.	Have a chronic or recurring illness?	☐ YES ☐ NO	16.	Ever had problems with joints (e.g. knees, ankles)?	☐ YES ☐ NO
3.	Ever been hospitalized?	☐ YES ☐ NO	17.	Have any skin problems (itching, rashes)?	☐ YES ☐ NO
4.	Ever had surgery?	☐ YES ☐ NO	18.	Have diabetes?	☐ YES ☐ NO
5.	Have frequent headaches?	☐ YES ☐ NO	19.	Have asthma?	☐ YES ☐ NO
6.	Ever had a head injury?	☐ YES ☐ NO	20.	Had mononucleosis in the past 12 months?	☐ YES ☐ NO
7.	Ever been knocked unconscious?	☐ YES ☐ NO	21.	Had problems with diarrhea/constipation?	☐ YES ☐ NO
8.	Wear glasses, contacts?	☐ YES ☐ NO	22.	Have problems with sleepwalking?	☐ YES ☐ NO
9.	Ever had frequent ear infections?	☐ YES ☐ NO	23.	If female, have an abnormal menstrual history?	☐ YES ☐ NO
10.	Ever passed out during or after exercise?	☐ YES ☐ NO	24.	Have a history of bed-wetting?	☐ YES ☐ NO
11.	Ever had seizures?	☐ YES ☐ NO	25.	Ever had a diagnosed eating disorder?	☐ YES ☐ NO
12.	Ever had chest pain during or after exercise?	☐ YES ☐ NO	26.	Ever had emotional difficulties such as depression for which professional help or medication was sought?	☐ YES ☐ NO
13.	Ever had high blood pressure?	☐ YES ☐ NO			
14.	Ever had back problems?	☐ YES ☐ NO	27.	Have you ever tested positive for HIV or AIDS?	☐ YES ☐ 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

Height _____ Weight _____ 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

_____ Eyes _____ Heart ____ Lungs _____ Ears _____ Spine _____ Extremities _____ Nose

_____ Urinalysis _____ Blood Pressure ____ Teeth _____ Skin _____ Abdomen _____ Throat

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

_____

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

Back: _____ Knees: _____ Ankles: _____

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 have 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