Work Experience USA - Health History Form

The health history form is a required medical exam and must be completed and signed by a doctor. Falsifying or failing to disclose information about your health may result in dismissal from the CCUSA program. If you have any questions or concerns about completing this form, please contact CCUSA. If additional space is needed, please attach a separate sheet.

PERSONAL INFORMATION

Last Name _____ First Name _____ Birth Date _____ Sex: ☐ Male ☐ Female

Home Address _____ _____ _____ _____
Number & Street City Postal Code Country

Home Phone # _____ Mobile Phone _____

Emergency Contact Name _____ Relationship _____

Home Phone _____ Mobile _____ Work Phone _____

Alternate contact in case of emergency: Name _____ Phone _____

Name of Doctor 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/Sumac
☐ Heart defect/disease		☐ Chicken Pox		☐ Insect stings
☐ Seizures		☐ 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 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 on participant in the 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 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 medications including over-the-counter, non-prescriptions, vitamins and supplements. Bring enough medication to last your entire program. 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

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
2. Have a chronic or recurring illness? ☐ Yes ☐ No
3. Ever been hospitalized? ☐ Yes ☐ No
4. Ever had surgery? ☐ Yes ☐ No
5. Have frequent headaches? ☐ Yes ☐ No
6. Ever had a head injury? ☐ Yes ☐ No
7. Ever been knocked unconscious? ☐ Yes ☐ No
8. Wear glasses, contacts? ☐ Yes ☐ No
9. Ever had frequent ear infections? ☐ Yes ☐ No
10. Ever passed out during or after exercise? ☐ Yes ☐ No
11. Ever had seizures? ☐ Yes ☐ No
12. Ever had chest pain during or after exercise? ☐ Yes ☐ No
13. Ever had high blood pressure? ☐ Yes ☐ No
14. Ever had back problems? ☐ Yes ☐ No
15. Ever had problems with joints (e.g. knees, ankles)? ☐ Yes ☐ No
16. Have any skin problems (itching, rashes, acne)? ☐ Yes ☐ No
17. Have diabetes? ☐ Yes ☐ No
18. Have asthma? ☐ Yes ☐ No
19. Had mononucleosis in the past 12 months? ☐ Yes ☐ No
20. Had problems with diarrhea/constipation? ☐ Yes ☐ No
21. Have problems with sleepwalking? ☐ Yes ☐ No
22. If female, have an abnormal menstrual history? ☐ Yes ☐ No
23. Have a diagnosed eating disorder? ☐ Yes ☐ No
24. Ever had emotional and/or mental difficulties? ☐ Yes ☐ No
    If YES, did you seek professional help? ☐ Yes ☐ No
    If YES, did you receive medication? ☐ Yes ☐ No
25. Have you ever tested positive for HIV? ☐ Yes ☐ No
26. Have you ever tested positive for Tuberculosis? ☐ Yes ☐ No

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

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, I risk dismissal from the CCUSA program. If a change in my health status occurs, I agree to notify CCUSA in writing of that change prior to leaving for the USA. I HEREBY CERTIFY that all statements contained 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.

If submitting this form electronically (emailing form) check the box below as an alternative to signing.

☐ Applicant's signature _____ Date _____

MEDICAL EXAMINATION—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Note to examining physician: This program involves rigorous physical activity and long working hours which can be taxing. Your exam should be directed to the person's mental and physical fitness to engage in such a program.

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 ☐ Blood Pressure ☐ Teeth ☐ Skin ☐ Abdomen ☐ Throat

Is this person on any medications that she/he will need to bring to the United States? (Please describe):

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

Back: _____ Knees: _____ Ankles: _____

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

If submitting this form electronically (emailing form) check the box below as an alternative to signing.

☐ Licensed Examining Physician's Signature _____ Date _____

Physician's Name (please print) Name _____ Phone _____

Address _____ _____ _____ _____

Number & Street City Postal Code Country