Health Screening

(To be completed by Applicant)

_______________________________ _______________________________ _______________________

Last Name First Name Date of Birth (MM/DD/YYYY)

Gender: Male Female **Height:** ___________ (in feet and inches) **Weight:** _____________ (in pounds)

General Health Questions: If you answer "Yes" to any of these general health questions please give full details on a separate sheet of paper.

Is your physical activity restricted in any way? Yes No

Do you have a chronic or recurring illness? Yes No

Have you ever been treated by a psychiatrist? Yes No

Do you have any dietary restrictions? Yes No

Are you currently taking any medications? Yes No

Have you ever undergone surgery? Yes No

Have you ever received treatment for a nervous or emotional issue? Yes No

Health History (Check all that apply)

Anemia	Dizziness/Fainting	Heart Disease	Mumps
Anorexia	Ear Infection	Hepatitis A/B/C	Pregnancy
Arthritis	Epilepsy/ Seizures	Kidney Disease	Rheumatic Fever
Asthma	Eye Problems	Malaria	Scarlet Fever
Bulimia	Gallbladder Problems	Measles	Tuberculosis
Chicken Pox	German Measles	Menstrual Problems	Ulcers
Depression	Glandular Fever	Migraine/ Headaches	Venereal Disease
Diabetes	Other		

If you check any of the above, please give details (including dates) on a separate sheet of paper.

Abnormalities of Organs or Systems (Check all that apply)

Cardiovascular	Head, ears ,nose, throat	Reproductive	Metabolic
Respiratory	Eyes (including glasses or contacts)	Gastrointestinal	Skin
Genitourinary	Musculoskeletal	Nervous	Other

If you check any of the above, please give details (including dates) on a separate sheet of paper.

Allergies (Check all that apply)

Allergies	Describe reaction:	Management or treatment:
Hay Fever		
Insect Sting		
Penicillin		
Other drugs		
Other:		

Insurance Information:

If you are a US citizen OR a J1 participant covered by a **different** insurance than that provided by your sponsor, please give details:

Carrier Name: ____ Contact Phone Number: ______________________________

Carrier/Plan Number: __________________________________ Group or Policy Number: _____________________________

Emergency Contact **Must speak English**

Name: ____ Relationship to Applicant: ______________________________________

Email: ____ Telephone: ____

I certify that all information given is true to the best of my knowledge, and I hereby give permission for emergency medical care should it be necessary.

____ ______________________

Signature **Date (MM/DD/YYYY)**

RV6 Effective 08/11/2016

Health Screening

(To be completed by Physician)

______________________________	______________________________	______________________
Last Name	First Name	Date of Birth (MM/DD/YYYY)

As a US summer camp employee, the above referenced applicant will be living in a community environment with young children and may be directly responsible for their well-being. It is therefore important that we are advised of any physical or mental health problems that may have a bearing on the applicant's ability to accept such responsibilities.

Please review the information provided by the applicant on Page 1 of this form and answer the following questions.

The above named applicant is in good physical condition. Yes No

The above named applicant does NOT have any physical issues that would negatively affect his/her work as a counselor/support staff at a US summer camp. Yes No

The above named applicant does NOT have any emotional issues that would negatively affect his/her work as a counselor/support staff at a US summer camp. Yes No

Comments:

Please check whether the applicant had been immunized against the following and provide the date of immunization:

Measles Date	Mumps Date	Rubella (German Measles) Date	Meningococcal Meningitis - MCV4 Date
Diphtheria Date	Tetanus Date	Pertussis Date	Varicella (Chicken Pox) Date
Hepatitis B Date	Hepatitis A Date	Polio – IPV Date	HIB Haemophilus Influenzae Type B Date
Rotavirus Date	Pneumococcal Conjugate – PVC 13 Date	TB Mantoux test Date	Whooping Cough Date
Tdap – 10 year Booster Date	H1N1 – Swine Flu Date	Most current Flu Shot Date	Typhoid Date

____ ______________________________________

Signature of Licensed Medical Personnel Date (MM/DD/YYYY)

____ ______________________________________

Printed Name of Licensed Medical Personnel Title

____ ______________________________________

Telephone Email