Health History Form

CCUSA

The participant and their doctor must complete all sections of this form. It must be completed in english as a fillable PDF or neatly hand written. Please provide as much detail as possible. Please upload this form to your Footprints account and take the original copy with you. Falsifying or failing to disclose information about your health may result in dismissal from the CCUSA program. Remember certain immunizations are REQUIRED. If you have any questions or concerns about this form, contact your local CCUSA Office. If additional space is needed, please attach a separate sheet.

PERSONAL INFORMATION - APPLICANT COMPLETE THIS SECTION

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 physician 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		☐ Whooping Cough*		☐ 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

*If you have not been immunized for this, then you need to discuss this matter with your Medical Practitioner/Doctor and ensure these shots/vaccinations/inoculations have been administered prior to arrival at your employer.

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 the program with a description of the restriction:

If you have listed any chronic health concerns, 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 **No**, please explain: _____

MEDICATIONS BEING TAKEN—APPLICANT COMPLETE THIS SECTION

Please list ALL current medications including over-the-counter, prescriptions, vitamins and supplements. Bring enough medication to last your entire trip overseas. 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. Attach additional sheet for more medications if needed.

☐ 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 _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

DIETARY RESTRICTIONS—APPLICANT COMPLETE THIS SECTION

☐ Vegetarian ☐ Vegan ☐ Lactose Intolerant ☐ Gluten Free

☐ Other dietary restrictions/food allergies _____

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 had problems with joints (e.g. knees, ankles)?	☐ Yes ☐ No
2.	Have a chronic or recurring illness?	☐ Yes ☐ No	16.	Have any skin problems (itching, rashes, acne)?	☐ Yes ☐ No
3.	Ever been hospitalized?	☐ Yes ☐ No	17.	Have diabetes?	☐ Yes ☐ No
4.	Ever had surgery?	☐ Yes ☐ No	18.	Have asthma?	☐ Yes ☐ No
5.	Have frequent headaches?	☐ Yes ☐ No	19.	Had mononucleosis in the past 12 months?	☐ Yes ☐ No
6.	Ever had a head injury?	☐ Yes ☐ No	20.	Had problems with diarrhea/constipation?	☐ Yes ☐ No
7.	Ever been knocked unconscious?	☐ Yes ☐ No	21.	Have problems with sleepwalking?	☐ Yes ☐ No
8.	Wear glasses, contacts?	☐ Yes ☐ No	22.	If female, have an abnormal menstrual history?	☐ Yes ☐ No
9.	Ever had frequent ear infections?	☐ Yes ☐ No	23.	Have a diagnosed eating disorder?	☐ Yes ☐ No
10.	Ever passed out during or after exercise?	☐ Yes ☐ No	24.	Ever had emotional and/or mental difficulties?	☐ Yes ☐ No
11.	Ever had seizures?	☐ Yes ☐ No		If YES, did you seek professional help?	☐ Yes ☐ No
12.	Ever had chest pain during or after exercise?	☐ Yes ☐ No		If YES, did you receive medication?	☐ Yes ☐ No
13.	Ever had high blood pressure?	☐ Yes ☐ No	25.	Have you ever tested positive for HIV?	☐ Yes ☐ No
14.	Ever had back problems?	☐ 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 contained in this 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 employer, I risk dismissal from the CCUSA program. If a change in my health status occurs, I agree to notify CCUSA and the employer I am placed at in writing of that change immediately and prior to leaving my home country. I hereby give permission for emergency medical care to take place should it be necessary. I HEREBY CERTIFY that all statements contained in this 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. I give permission for CCUSA to contact my doctor for any additional information.

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

☐ Applicant's signature _____ Date _____

IMMUNIZATION HISTORY—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Please record the month and year of your immunizations (note some require multiple doses so please list the date of your final dose. Where applicable also include your latest Booster date.

Vaccines	Immunization	Booster	Vaccines	Immunization	Booster
DPT series* (Diphtheria, Pertussis, Tetanus)			Tetanus		
MMR* (Mumps, Measles, Rubella)			Small Pox		
Polio*			Typhoid		
Hepatitis B					

**Required Immunizations (if expired new immunizations MUST be taken)*

Have you ever be vaccinated against Tuberculin? ☐ Yes ☐ No If Yes - List date: _____

If No - Understand that your employer may require you to get this done in your home country or if not offered in your home country when you arrive at your place of employment (at your own expense). If this is the case you will need to discuss this directly with your employer.

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 take with them overseas? (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) _____ Phone _____

Address _____ _____ _____ _____

Number & Street City Postal Code Country