

Stagedoor Manor

HEALTH HISTORY

Name: _____ Sex: M ___ F___ Age: _____ Date of Birth: _____

Address: _____

Country Code: _____ City Code: _____ Telephone: _____

IN AN EMERGENCY PLEASE NOTIFY: Name _____

Address _____

Country Code _____ City Code _____ Telephone: _____

TO THE PHYSICIAN: This person will serve up to four months in the USA as a leader in summer camp for children or as support staff in the kitchen, office, or maintenance department of a summer recreational facility. Your careful examination and written recommendations will encourage physical wellness and safe participation in strenuous activities.

HEALTH HISTORY: (Please indicate **YES** or **NO** and give approximate dates)

DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE
Asthma				Fainting				Rheumatic Fever			
Malaria				Heart trouble				Hepatitis			
Chicken Pox				Measles				Seizures			
Convulsions				Mumps				H.I.V./A.I.D.S.			
Diabetes				German Measles							
Meningitis											

Tuberculosis (TB) causes more deaths worldwide than any other infectious disease.

- **Screening:** You must provide documentation of TB screening (PPD or Mantoux skin test read in millimeters of duration) taken within the past 12 months.
- **Chest X-ray:** Anyone with a positive skin test should have a chest x-ray. You must bring chest x-ray films or an official x-ray report signed by your physician. X-rays must have been done within the last 12 months. A negative chest x-ray is not a substitute for a skin test.
- **Treatment:** If you have been treated for TB infection or disease, please provide documentation.

ALLERGIES: For Example: Hay Fever, Poison Ivy, Insect Stings, Penicillin, Other Drugs, Food or Animals.

Operations for serious injuries _____

Chronic or recurring illnesses _____

Other diseases or details related to the above _____

Do you currently have a medical condition requiring the regular intake of medication? Yes ___ No ___

If yes, please list: _____

Any history of emotional or mental disturbances? Yes ___ No ___

Have you ever suffered from an eating disorder? Yes ___ No ___ If yes, provide separate description.

(For women) Is menstrual history normal? Yes ___ No ___

If no, are there any special considerations to be made? _____

(For women) Are you pregnant? Yes ___ No ___

The Health History Form must be completed by a licensed physician. The physician must determine applicant's fitness to engage in strenuous activities.

Please indicate whether the following are satisfactory (S), unsatisfactory (U) or not examined (NE):			
Eyes	Lungs	Skin	
Glasses	Heart	Allergy (please specify)	
Ears	Hernia		
Nose	Abdomen		
Throat	Extremities		
Genitalia	Posture (Spine)		

IMMUNIZATION HISTORY: Please record dates of basic immunizations. Required immunizations are determined by each U.S. state. Participant should ask U.S. site director which are required.

Polio	Typhoid	Diphtheria
Tetanus	Tuberculin Test	Mumps Measles
Measles	Rubella (German Measles)	Other

General Appraisal: _____

Special Diet: _____

Are you a vegetarian? _____

Are you presently or have been in the last two years on any medication? If yes, explain _____

Any Restrictions On: Swimming/Diving ___ Camping/Hiking _____

Strenuous activity in sports _____ Other _____

Do you smoke? Yes ___ No ___ If yes, are you prepared *not* to smoke on camp premises? _____

Do you have any visible tattoos or body piercing? If yes, please explain _____

Do you consume alcoholic beverages? Yes ___ No ___ If yes: Daily ___ Weekly ___ Every 2 weeks ___ On special occasions _____

FOR PHYSICIAN: I have examined this person and have reviewed the health history. It is my opinion that this person is physically able to engage in strenuous activities, except as noted above.

Signature of licensed examining physician Date

Telephone: _____ Address: _____

FOR PARENTS OF PARTICIPANTS UNDER 21 YEARS OF AGE: In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the U.S. site director to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child as named above.

Signature of parent Date