



# United States Youth Conservation Corps

## Crew Member Medical History Form



NOTE: The collection of this information is authorized by Public Law 93-408. The purpose of this data is to safeguard the health, safety and welfare of the enrollees of the YCC programs and may be provided to a physician in the event medical treatment is necessary. This information is requested on a voluntary basis; however, failure to complete this form may result in exclusion from the program.

### Medical History

Please answer the following questions regarding your background, contact and other information.

First name	Middle name	Last name	Suffix
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other/Does not identify	Date of Birth (MM/DD/YYYY)	Age	
Address Street	City	State	Zip
Email	Home Phone	Cell Phone	
Do you have Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, provide insurance company name and policy number.		
Physician Name	Physician Phone Number		
Address Street	City	State	Zip

Have you had or are you having any of the following health conditions?

Enter X where appropriate and describe on page 3.

Allergies	Frequent infections	Other health conditions		
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Cold	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Rheumatism or arthritis	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Swollen or painful joints
<input type="checkbox"/> Poison ivy or oak	<input type="checkbox"/> Ear ache	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Insects stings	<input type="checkbox"/> Bladder or intestinal infection	<input type="checkbox"/> Difficulty with balance	<input type="checkbox"/> Mental health condition	<input type="checkbox"/> Other (Identify)
<input type="checkbox"/> Skin condition	<input type="checkbox"/> Other (Identify)	<input type="checkbox"/> Fainting	<input type="checkbox"/> Persistent cough	
<input type="checkbox"/> Other (Identify)		<input type="checkbox"/> Heart condition	<input type="checkbox"/> Shortness of breath	
		<input type="checkbox"/> Hernia	<input type="checkbox"/> Problem with blood not clotting	

Are you currently taking any medication?  
 Yes. If yes, explain on separate page.  
 No

Are you allergic to any medication?  
 Yes. If yes, explain on separate page.  
 No

### Immunization history

Enter X where appropriate and dates as indicated. A Tetanus and Diphtheria shot is required unless you have received one or a booster within the last ten years. You may attach your immunization record as a separate document.

	Date of the original series (MM/DD/YYYY)	Date of last booster to ensure immunization (MM/DD/YYYY)
Tetanus, Diphtheria, Pertussis (Tdap)		
Polio Vaccine (IPV)		
Measles, Mumps, Rubella (MMR)		
Meningococcal Conjugate Vaccine (MCV)		

To my knowledge, I have not been exposed to a contagious or infectious disease in the past three weeks, and I am in a state of health which would allow full participation in all YCC activities.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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To be completed by Parent/Guardian

Emergency Contact First Name	Last Name	Relationship	
Address Street	City	State	Zip
Email	Phone 1	Phone 2	

Please clearly outline any medications that the applicant is taking including the name and dosage. If necessary, please also outline specific instructions for any medications that a YCC Program Staff will need to administer to the YCC Crew Member. Please use the space below or continue on page 3.

Please identify on page 3, any condition below that would restrict full participation and describe any special care or treatment that may be required.

### Basic functional requirements for outdoor work

a. Heavy lifting, 45 pounds and over	g. Use of fingers	m. Repeated bending
b. Heavy carrying, 45 pounds and over	h. Both hands required	n. Climbing, legs only
c. Straight pulling	i. Walking	o. Climbing, use of legs and arms
d. Pulling hand over hand	j. Standing	p. Both legs required
e. Pushing	k. Crawling	q. Far vision correctable in one eye to 20/20 and to 20/40 in the other
f. Reaching above shoulder	l. Kneeling	r. Hearing (aid permitted)

### Environmental Factors

a. Outside	f. Dry atmospheric conditions	j. Working around moving objects or vehicles
b. Excessive heat	g. Excessive noise, intermittent	k. Working on ladders or scaffolding
c. Excessive cold	h. Dust	l. Working with hands in water
d. Excessive humidity	i. Slippery or uneven walking surfaces	m. Working closely with others
e. Excessive dampness or chilling		n. Working alone

I certify that I am familiar with the Youth Conservation Corps Program and that I give my consent to my son/daughter/ward to participate in the program as a YCC member. I understand that I will not hold the United States Government responsible for any nonprogram accident or illness, and I authorize first aid, or emergency medical care, to be performed at the nearest, most adequate facility approved by the YCC.

Parent/Guardian Signature

Date (MM/DD/YYYY)

PRIVACY ACT STATEMENT FOR THE YCC MEDICAL HISTORY FORM (FS-1800-3) 10/94

The following information is provided to comply with the Privacy Act of 1974 (PL-579). 5 U.S.C 301 and 7 CFR 260 authorize acceptance of the information requested on this form. Collecting this information is necessary to assist the agency in safeguarding the health, safety, and welfare of the enrollees of the YCC programs and may be provided to a physician in the event medical treatment is necessary. This information is requested on a voluntary basis, failure to complete this form will result in exclusion from the program. Privacy Act System of Records USDA/FS-27 Enrollee Medical Records covers the collection and storage of, and access to these records.

BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0596-0084. The time required to complete this information collection is estimated to average 14 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.

Reviewing Officer's Signature

Date (MM/DD/YYYY)

# United States Youth Conservation Corps

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### Additional Information

Please use this space to provide any additional information.