International Exchange of North America

3 Adventures Camp Program Health History Form Guidelines 2017

As 3 Adventures International Camp Staff Program participants, you may be required to complete a medical form by your camp. This is a generally accepted form but please check with camp after securing employment. They may have their own camp specific form for you to complete.

- Sections 1 and 2 should be completed and signed by you. Section 3 can be completed by you or your physician, but it must be signed by a physician
- Medical forms must be completed and signed by you and a physician or nurse practitioner, with knowledge of your medical history
- Physicians may charge a fee for signing your medical form. Fee's for your medical form are your responsibility and is in addition to any program fees paid to IENA
- If you have not yet been placed at a camp, please complete this medical form. However, if you have been placed at a camp they may prefer it if you completed their own medical form. If this is the case, please follow camps advice.
- If you are under 18 at the time you complete this medical form, you are required to have a parent or legal guardian co-sign the form.
- The information provided on your medical form should be based on an examination completed **within the last two years**. IENA does not require that you attend a medical examination for completion of this form, **however** you may need to submit to a medical examination if you have not had one within the last two years ***or*** if your physician specifies otherwise.
- You must take the original copy of your medical form to camp. Failure to do so may result in the termination of your camp contract.
- All participants on the 3 Adventures International Camp Staff program are provided with **up to 120 days** of medical insurance as standard. This insurance does ***not*** cover treatment or medication for pre-existing conditions (see insurance section of your control panel for a definition) or most dental treatment.
- You must declare all pre-existing medical conditions and medications on your online application and on your medical form. You may wish to purchase additional insurance to cover you for the duration of your travels. This is your own responsibility

Important - Note to medical professional completing this form

The person who has presented this form has applied to work in an American summer camp for the upcoming summer on a 3 Adventures Camp program. Applicants will be put in direct contact with children of all ages, which could cause considerable stress.
They will have a duty of care for the campers who come under their responsibility and their role will involve leading a range of physical activities. Throughout the summer season, they are likely to be exposed to working long hours, in hot weather. For someone without any pre-existing conditions, a role working within the camp environment will not pose any health issues.

Should you feel that this individual has a pre-existing medical condition that would restrict their ability to work in the summer camp environment, we ask that you indicate as such in the summary box in Section 3 of the Health History Form. Please also provide a supporting letter to outline the reason behind your decision to recommend against the individual participating in the program.

There is no liability associated with your recommendation of suitability. The information contained within this form is strictly only for the use of the health care staff at camp and for the purpose of gaining an understanding of the individual's medical history, should treatment be required.

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Health History Form Section 1

First Name(s): (as shown on passport)	Surname: (as shown on passport)		Date of Birth (M/D/YY):
Nationality: (as shown on passport)	Gender (M/F):	Marital status:	Age:
Home address (Permanent - students should **NOT** your student accommodation address):			
			Postcode:
Home phone number:	Mobile phone number:		
Name of Emergency Contact:	Relationship to Emergency Contact:		
Address of Emergency Contact:			
			Postcode:
Emergency contact phone number 1:	Emergency contact phone number 2:		

Allergies: *Check those that apply to you. Completion of this section is voluntary, yet helpful to healthcare staff.*

_____ I have no known allergies.

_____ I have an allergy to this food: _____ This causes anaphylaxis? ☐ Yes ☐ No

Describe what happens if you eat this food and how the reaction is managed:

_____

_____

_____

_____ I am allergic to this medication(s): _____ This causes anaphylaxis? ☐ Yes ☐ No

_____ I am allergic to these substances: _____ This causes anaphylaxis? ☐ Yes ☐No

Describe what happens if you are exposed to these medications or substances and how the reaction is managed:

_____

_____

Nutrition: *Our expectation is that staff set an example for campers by eating the provided meal. We work with some medically prescribed diets, such as gluten-free and lactose intolerant, but cannot cater to individual food preferences. Discuss concerns with your camp director prior to the start of camp.*

_____ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

_____ I am a vegetarian of this type:

- ☐ Semi-vegetarian (no pork or beef)
- ☐ Pesco (no pork, beef, or chicken)
- ☐ Lacto (no meats, fish, seafood, or eggs)
- ☐ Ovo (no meats, fish, seafood, or dairy)
- ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
- ☐ Vegan (no meats, seafood, eggs, or dairy)

_____ I do not eat _____ products because of religious beliefs.

Chronic Concerns: *Check all that pertain to you and provide information about supportive healthcare. Completion of this section is voluntary, yet helpful to healthcare staff.*

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s):

- ☐ Asthma
- ☐ Diabetes
- ☐ Fainting
- ☐ Back pain or injury
- ☐ Headaches, Migraines
- ☐ Difficulty breathing
- ☐ Surgical history
- ☐ Knee or ankle weakness
- ☐ Sleep problem
- ☐ Dysmenorrhea
- ☐ Seizure disorder: _____
- ☐ Other: _____

Your supervisor expects that staff who have chronic health concerns are capable of performing the essential functions of the job for which they have been hired. If you have any concerns, please speak with your supervisor.

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Health History Form Section 2

General Physical History: *If you answer "Yes" to any of these questions, provide more information at the end of this section.*

Completing this session is voluntary, but helpful to healthcare staff.

1. Have you ever been hospitalized? ☐ Yes ☐ No
2. Have you ever passed out during or after exercise? ☐ Yes ☐ No
3. Have you ever been dizzy during or after exercise? ☐ Yes ☐ No
4. Have you ever had chest pain during or after exercise? ☐ Yes ☐ No
5. Do you tire more quickly than your friends during exercise? ☐ Yes ☐ No
6. Have you ever had high blood pressure? ☐ Yes ☐ No
7. Have you ever had a racing heartbeat or skipped heartbeats? ☐ Yes ☐ No
8. Have you ever been knocked out or become unconscious? ☐ Yes ☐ No
9. Have you ever had a seizure? ☐ Yes ☐ No
10. Have you ever had a stinger, burner, or pinched nerve? ☐ Yes ☐ No
11. Have you ever had heat or muscle cramps? ☐ Yes ☐ No
12. Have you ever been dizzy or passed out in the heat? ☐ Yes ☐ No
13. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling, or other injuries to any of your body areas? ☐ Yes ☐ No

    If so, where? ☐ Head ☐ Shoulder ☐ Leg ☐ Neck ☐ Chest ☐ Arm, hand ☐ Ankle ☐ Back ☐ Hip ☐ Foot

14. Have you been in countries other than the United States in the past nine months? ☐ Yes ☐ No

    If yes, list the countries and the time spent in them.

    Country: _____ Dates: _____

    Country: _____ Dates: _____

    Country: _____ Dates: _____

Use the space below to explain and/or provide more detail about the General Physical Health questions to which you responded "Yes."

_____ _____

_____ _____

_____

_____

_____ _____

Name of your physician: _____ Office Phone (_____)_____

Name of your dentist/orthodontist: _____ Office Phone (_____)_____

Authorization for Healthcare:

This health history is correct. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp's Health Center staff in providing care to me and may be reviewed by my work supervisor(s).

Signature of Staff Person: _____ *Date:* _____

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Health History Form Section 3

General Examination Immunization History:

First Name(s): (as shown on passport)		Last name: (as shown on passport)		Date of Birth:	

General examination	Not examined	Satisfactory	Unsatisfactory	Immunization history (Please tick 'Yes' or 'No'; provide details)	YES	NO	Dates/Details
Abdomen				Diphtheria			
Blood Pressure				Hepatitis A			
Ears				Hepatitis B			
Eyes				Measles			
Extremities				MMR			
Heart				Mumps			
Lungs				Polio			
Nose				Tetanus			
Skin				Typhoid			
Spine				Chicken Pox			
Teeth				H1N1 (Swine Flu)			
Throat				Tuberculin test			(Please list result)

General Health and Nutrition	YES	NO
Do you/have you suffered from an eating disorder? If yes, please describe:		
Do you have any medical or physical limitations that will restrict your participation in camp activities such as camping, hiking, swimming, diving, etc.? If yes, please describe:		
Do you currently undertake any activities for personal fitness? Please describe:		
Do you suffer from frequent migraines or headaches? If yes, please describe frequency:		
Do you smoke? If yes, please describe frequency:		
Do you drink alcohol? If yes, please describe frequency:		
Summary Based on the information given in this form and cover letter, is this participant fit to perform the responsibilities of a staff member working at summer camp in America?		

This information is valid in regard to my current health status. If my current health status changes, I agree to notify camp and 3 Adventures immediately.

Applicant's signature: Date:

Applicants under 18 at the time of completion of this form must obtain a parent's signature. I herby confirm that the information given by the applicant is valid in regard to their current health status.

Parent's signature: Date:

I hereby verify the medical health history of the above named person. It is my opinion that this person is able to engage in physical activities at camp, unless otherwise indicated above.

Physician's Name & Address: Signature:

Date: