OMB No. 0596-0084

Youth Conservation Corps (YCC) Application

YCC Exhibit I.1

Print or Type all answers. All questions and statements must be answered to enable Selection Office to determine applicant's eligibility and availability. *Incomplete applications may have to be rejected.* Authority is PL 93-408. During the term of employment, you must be at least 15 years of age and not have reached age 19.

Name (Last-First-Middle Initial)

Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

☐ Male

☐ Female

Date of Birth

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Mailing Address (Street or P.O. Box)

City

State Zip Code

Area Code Telephone Number

☐☐☐ - ☐☐☐ - ☐☐☐☐

Home

Area Code Telephone Number

☐☐☐ - ☐☐☐ - ☐☐☐☐

In Case of Emergency

Applicant's Statement

YCC is an Equal Opportunity Employer

I am familiar with the YCC program and interested in working in the outdoors to develop and maintain the natural resources of the United States. If selected, I will obtain a work permit if required. I have or am applying for a social security number. I am a permanent resident of the United States or its Territories or possessions. I do not have a history of serious criminal or other antisocial behavior that might jeopardize my safety or that of others. I certify that all information I have given above is true and correct to the best of my knowledge. I have not participated in any YCC program for more than 3 weeks in the past, nor have I submitted duplicated applications. Incorrect statements constitute grounds for immediate dismissal. You have my permission to give this application to any YCC official for whose camp I am selected.

(Signature of Applicant) (County)

I am familiar with the YCC program and the applicant has my permission to participate.

(Signature of Parent or Guardian) (Date)

OMB No. 0596-0084
Exhibit I.2

Youth Conservation Corps
Medical History

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 treatment is necessary. This information is requested on a voluntary basis: however, failure to complete this form will result in exclusion from the program.

Part I - To be completed by applicant

1. Name (*Last, First, Middle Initial*)	2. Address (*Street, City, State, including Zip Code*)	
3. Do you have health and accident insurance? ___ Yes ___ No If yes, list name of insurer in block 4.	4. Insured by and policy number.	5. Date of birth *(Mo/Da/Yr)*
6. Diseases *(Enter x if you have had any of the diseases.)* ___ Rheumatic ___ Tuberculosis ___ Diabetes	7. Describe treatment if disease marked in block 6.	

8. Have you had or are you having any of the following health conditions *(Circle where appropriate and describe on back)*

Allergies	**Frequent Infections**		**Other health conditions**		
Hay fever	Colds	Convulsions	Hernia	Diabetic	Emotional problem
Asthma	Sore throat	Fainting	Poor hearing	Pregnancy	Back trouble or injury
Poison ivy or oak	Ear ache	Sleep walking	Difficulty with sense of balance	Swollen or painful joints	Persistent cough
Insect stings	Bladder or intestinal infection	Headache	Poor vision	Shortness of breath	Rheumatism or arthritis
Skin condition	Venereal disease	Stuttering	Problem with blood not clotting	Chest pains	Loss of weight
Other *(identify)* ____	Other *(identify)* ____	Nervous condition Ulcers	Defects in legs or feet	Easy fatigue Heart condition	Lyme disease Other *(identify)* ____

9. a. Are you currently taking any medication? ___ Yes ___ No - if yes, explain on back.

b. Are you allergic to any medications? ___ Yes ___ No - if yes, explain on back.

10. 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)*

	Date of original series	Date of last booster to insure immunization
___ Diphtheria	_____	_____
___ Polio Vaccine	_____	_____
___ Tetanus Toxoid	_____	_____

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 *(Read above statement before signing)*	Date

Part II - To be completed by parent or guardian of the applicant

This is to certify that I am familiar with the Youth Conservation Corps Program and that I give my consent to my son/daughter/ward to participate with the program as a YCC member. I understand that I will not hold the United States Government responsible for any non-program 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.

1. Emergency contact *(Name and Relationship)*	2. Home Phone ( )	3. Work Phone ( )
4. Address (Street, City, State and Zip Code)		
5. Signature (Parent or Guardian)		6. Date

Identify in remarks block, any condition that would restrict full participation and describe any special care or treatment that may be required.

Basic functional requirements for outdoor work

1. Heavy lifting, 45 pounds and over
2. Heavy carrying 45 pounds and over
3. Straight pulling
4. Pulling hand over hand
5. Pushing
6. Reaching above shoulder
7. Use of fingers
8. Both hands required
9. Walking
10. Standing
11. Crawling
12. Kneeling
13. Repeated bending
14. Climbing, legs only
15. Climbing, use of legs and arms
16. Both legs required
17. Far vision correctable in one eye to 20/20 and to 20/40 in the other
18. Hearing (aid permitted)

Environmental factors

1. Outside
2. Excessive heat
3. Excessive cold
4. Excessive humidity
5. Excessive dampness or chilling
6. Dry atmospheric conditions
7. Excessive noise, intermittent
8. Dust
9. Slippery or uneven walking surfaces
10 Working around moving objects or vehicles
11. Working on ladders or scaffolding
12. Working with hands in water
13. Working closely with others
14. Working alone

REMARKS *(Enter information regarding any prescribed medication, reactions to penicillin or any drugs and/or any other health problems of which we should be made aware.)*

7. FS Reviewing officer's signature	8. Date

*U.S. GPO: 1991-818-871/40475