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 (mm/dd/yyyy)

6. Diseases (Enter x if you have had any of the diseases.)
☐ Rheumatic Fever
☐ 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 (Enter x where appropriate and describe on back)

Allergies
☐ Hay fever
☐ Asthma
☐ Poison ivy or oak
☐ Insects stings
☐ Skin condition
☐ Other (Identify) _____

Frequent infections
☐ Cold
☐ Sore throat
☐ Ear ache
☐ Bladder or intestinal infection
☐ Venereal disease
☐ Other (Identify) _____

Other health conditions
☐ Convulsions
☐ Fainting
☐ Sleepwalkin
☐ Headache
☐ Stuttering
☐ Nervous condition
☐ Ulcers
☐ Hernia
☐ Poor hearing
☐ Difficulty with sense of balance
☐ Poor vision
☐ Problem with blood not clotting
☐ Defects in legs or Feet
☐ Heart condition
☐ Diabetic
☐ Pregnancy
☐ Swollen or painful joints
☐ Shortness of breath
☐ Chest pains
☐ Easy fatigue
☐ Lyme disease
☐ Emotional problem
☐ Back trouble or injury
☐ Persistent cough
☐ Rheumatism or arthritis
☐ Loss of weight
☐ 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 Diptheria short 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
[x]	Diptheria	_____	_____
[x]	Polio Vaccine	_____	_____
[x]	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 (mm/dd/yyyy)

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 State Government responsible for any nonprogram accident or illness, and I authorize first aid, or emergency medical care, to be perform 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 (mm/dd/yyyy)

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 permited)

Environmental factors

1. Outside
2. Excessive heat
3. Excessive cold
4. Excessive humidity
5. Excessive dampness or chilling
6. Dry atmospheric conditions
7. Excessive nose, intemittent
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 other
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.)*

PRIVACY ACT STATEMENT
FOR
THE YCC MEDICAL HISTORY (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 treament is necessary. This information is requested on a voluntary basis, failure to complete this form will result in exclusion from the program.

According to the Paperwork Reduction Act of 1995, no agency may conduct or sponsor, and no person is required to respond to , a collection of information unless it displays a valid OMB approval number. The OMB approval number for this collection is 0596-0084. Public reporting burden for this collection of information is estimated to average 3 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.

7. FS Reviewing officer's signature	8. Date (mm/dd/yyyy)