SCA MEDICAL HEALTH HISTORY FORM

CANDIDATE INFORMATION

Please fill the Medical Health History Form ensuring that all sections are complete. If the candidate is a **minor**, this form must be signed by a parent/guardian.

Last Name _____ First _____ Middle _____

Age _____ Date of Birth _____/_____/_____ Height _____ Weight _____ Gender _____

Home Address _____ City _____ State _____ Zip Code _____

Daytime or Cell Phone _____ Home Phone _____ Email Address _____

EMERGENCY CONTACT AND MEDICAL INSURANCE INFORMATION

We reserve the right to notify your emergency contact in the event of a medical or other emergency or other circumstance in which we believe your physical and/or emotional well-being, or that of others, is at risk.

Name _____ Name _____

Day Phone _____ Evening Phone _____ Day Phone _____ Evening Phone _____

Email _____ Email _____

Relationship _____ Relationship _____

Language spoken at home _____ Language spoken at home _____

For our insurance records, please complete the following questions:

Is the candidate covered by a hospitalization and medical policy? _____

If yes, please indicate insurance company, Policy/Certificate Number _____

Head of Family name _____

Physician's name and phone number _____

Members/Parents/Guardians: The SCA is an equal opportunity employer and endeavors to provide a multitude of environmental service opportunities to all interested individuals. Most SCA programs are outdoors and are physically and emotionally demanding. We strive to accommodate most medical conditions. Our goal in collecting medical information is to create safer programs for members and staff. We believe that knowing critical health information is crucial to making good decisions about safety and work practices. In that effort, SCA requires all members and staff to complete a Medical Health History Form. SCA staff treats all personal health information with the highest degree of confidentiality. Your personal medical information will be stored in a location that protects your privacy and medical information will be shared with SCA supervisory staff on an as-needed basis only.

If you (or the minor member) arrive at the program start with a pre-existing medical, behavioral or psychological condition which is not indicated on your medical form you may be asked to leave.

GENERAL HEALTH QUESTIONS – LAST 2 YEARS ONLY

	Yes/No		Yes/No
1. Allergies: food, environmental, medications		20. Are you currently under the care of a physician besides routine care?	
2. Any Surgery in the past 2 years (excluding oral)?		21. Back Pain?	
3. Bleeding or Blood Disorders?		22. Chronic or infectious illness or condition? (ie: lyme disease, tuberculosis, etc).	
4. Circulation problems (ie: Raynaud's)		23. Frequent dizziness or fainting?	
5. Do you use tobacco? *		24. Diabetes?	
6. Do you use any medical equipment/devices (ie: braces, nebulizer, prostheses)?		25. Hearing impairment	
7. Gastrointestinal problems?		26. Frequent headaches or Migraines?	
8. Head injury where you lost consciousness.		27. Heart condition / problems, including heart murmurs, SVT, etc.	
9. Heat Exhaustion or Heat Stroke?		28. Active or history of hepatitis?	
10. Chest pain or pressure?		29. High Blood Pressure?	
11. Is there a history of cardiovascular disease in your family?		30. History of obesity	
12. Bone or joint problems that includes fractures, sprains, breaks, etc		31. Pinched nerve(s)?	
13. Seizures/neurological disorder		32. Infectious skin condition	
14. Sickle-cell anemia or trait?		33. Vision impairment other than glasses/contacts?	
15. Dietary Restrictions, such as, vegetarian, vegan, lactose intolerant, etc.		34. History of altitude sickness	
16. Hospitalization or ER visit in the past year?		35. Hypoglycemia	
17. History of multiple urinary tract infections		36. Are you currently pregnant?	
18. Severe menstrual cramps		37. Are there any other medical issues / concerns that are not listed?	
19. Do you have Asthma?			

***SCA follows all state and federal laws regarding tobacco use.**

Swimming Ability:

General Condition Information - Please explain any "YES" answers. Please note the question number and **state the specific date and extent of injury/illness.** Being thorough may eliminate the need for further follow-up with SCA staff.

Candidate Name_____

PERSONAL HISTORY

Have you been diagnosed or have you experienced any of the following conditions in the past year?

☐Yes ☐No	Adjustment disorder	☐Yes ☐No	Developmentally Disabled
☐Yes ☐No	Asperger/Autism	☐Yes ☐No	Learning/Auditory Processing Disorder
☐Yes ☐No	Anxiety disorder	☐Yes ☐No	Self Harm/Suicidal thoughts
☐Yes ☐No	Behavioral Issues	☐Yes ☐No	Schizophrenia
☐Yes ☐No	Bipolar Disorder	☐Yes ☐No	Substance Use/Abuse
☐Yes ☐No	Depression/Mood Disorder	☐Yes ☐No	Motivational/Homesickness
☐Yes ☐No	Eating Disorder	☐Yes ☐No	Other

Are you, or have you been, in counseling in the last 6 months? ☐Yes ☐No

If Yes, please arrange to sign a Release of Information with your Counselor.

MEDICATIONS

☐ **NONE**

(or list to right)

Medication				
Condition				
Dosage				
Medication Frequency				
Date Started				
Side effects				
Medication Appearance				
Medication Method				
Do you plan to discontinue this medication?				

HOSPITALIZATIONS

☐ **NONE**

(or list to right)

Date of Visit/Admittance	**Reason**	**Length of Stay**

ALLERGIES

☐ **NONE**

(or list to right)

Allergy			
Date of last reaction			
Type of Reaction			
Reaction occurs by:			
Medication or Treatment Required			
If Epinephrine is required, I will bring 2 delivery devices:			

ASTHMA

☐ **NONE**

(or list to right)

How long have you had asthma?	
What causes or triggers your asthma episodes?	
What are your symptoms and severity?	
When was your last asthma attack?	
How often do you have asthma attacks/symptoms?	
Which description best describes your asthma's current condition? Stable, worsening or improving?	
Have you ever required emergency treatment or hospitalization for your asthma? If yes, when and what were the circumstances?	

Asthma Medication	Dosage	How Often	Last Used

AUTHORIZATION TO TREAT

The information provided in this document is correct and complete to the best of my knowledge. The person herein described has permission to engage in all program activities except as noted. I hereby give permission to SCA to provide routine health care and assist with medication therapy of prescribed and over-the-counter (OTC) medications. I agree to the release of any records necessary for insurance purposes. I give permission to SCA to arrange necessary transportation for my child.

Signature of Responsible Adult/Guardian or adult applicant: _____

Printed Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in program activities.

Signature of Minor or Individual: _____ Date: _____