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

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

7.
a. Are you currently taking any medication? ☐ Yes- if yes, explain on back ☐ No
b. Are you allergic to any medications? ☐ Yes- if yes, explain on back ☐ No

8. Immunization history *(Enter X where appropriate and dates as indicated. A Tetanus and Diptheria 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 ensure Immunization
☐ Diptheria		
☐ 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 the statement above 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 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.

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/yyyyy)

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

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 permited)

Environmental factors

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

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. 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 20 minutes/hours 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.

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