



## Youth Conservation Corps Medical History

FSM 1840

To be completed by YCC selected participants only

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

### Part I - To be completed by applicant

Name (Last, First, Middle Initial)	Address (Street, City, State, including Zip Code)
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Date of birth (mm/dd/yyyy)	Do you have health and accident insurance? <input type="checkbox"/> Yes If yes, list name of insurer  <input type="checkbox"/> No	Insured by  policy number
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Primary Care Physician name Address	Physician phone number (     )     -     -
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Have you had or are you having any of the following health conditions? Enter x where appropriate and describe on back or  check here if attached as a separate document

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

Are you currently taking any medication?  Yes- if yes, explain on back or check here  if attached  No

Are you allergic to any medications?  Yes- if yes, explain on back or check here  if attached  No

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. You may attach your immunization record as a separate document.

<input type="checkbox"/> Check here if immunization records are attached as a separate document.	Date of original series (mm/dd/yyyy)	Date of Last Booster to ensure Immunization (mm/dd/yyyy)
<input type="checkbox"/> Tetanus Toxoid, Diphtheria, Pertussis (Tdap)		
<input type="checkbox"/> Polio Vaccine (IPV)		
<input type="checkbox"/> Measles, Mumps, Rubella (MMR)		
<input type="checkbox"/> Meningococcal Conjugate Vaccine (MCV)		

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)
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<b>Part II - To be completed by parent or guardian of the applicant</b>		
This is to certify that I am familiar with the Youth Conservation Corps (YCC) 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 program staff.		
Emergency contact (Name and Relationship)	Home Phone (       )       -	Work Phone (       )       -
Address (Street, City, State and Zip Code)	Alternate or preferred form of contact <i>i.e.</i> email, text, alternate phone, etc. (optional)	
Signature (Parent or Guardian)	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.		
<b>Basic functional requirements for outdoor work</b>		
a. Heavy lifting, 45 pounds and over b. Heavy carrying, 45 pounds and over c. Straight pulling d. Pulling hand over hand e. Pushing f. Reaching above shoulder	g. Use of fingers h. Both hands required i. Walking j. Standing k. Crawling l. Kneeling	m. Repeated bending n. Climbing, legs only o. Climbing, use of legs and arms p. Both legs required q. Far vision correctable in one eye to 20/20 and to 20/40 in the other r. Hearing (aid permitted)
<b>Environmental factors</b>		
a. Outside b. Excessive heat c. Excessive Cold d. Excessive humidity e. Excessive dampness or chilling	f. Dry atmospheric conditions g. Excessive noise, intermittent h. Dust i. Slippery or uneven walking surfaces j. Working around moving objects or vehicles	k. Working on ladders or scaffolding l. Working with hands in water m. Working closely with others n. 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 medical treatment 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 14 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.

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