FS-1800-3 (v12/2016)
OMB No. 0596-0084
Exp.xx/xx/20xx

United States Youth Conservation Corps
Crew Member Medical History Form

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.

Medical History

Please answer the following questions regarding your background, contact and other information.

First name | Middle name | Last name | Suffix

Gender ☐ Male ☐ Female ☐ Transgender ☐ Other/Does not identify | Date of Birth (MM/DD/YYYY) | Age

Address Street | City | State | Zip

Email | Home Phone | Cell Phone

Do you have Health Insurance? ☐ No ☐ Yes | If yes, provide insurance company name and policy number.

Physician Name | Physician Phone Number

Address Street | City | State | Zip

Have you had or are you having any of the following health conditions?

Enter X where appropriate and describe on page 3.

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
- ☐ Other (Identify)

Other health conditions
- ☐ Chest pains
- ☐ Convulsions
- ☐ Diabetic
- ☐ Difficulty with balance
- ☐ Fainting
- ☐ Heart condition
- ☐ Hernia
- ☐ Rheumatism or arthritis
- ☐ Loss of weight
- ☐ Lyme disease
- ☐ Mental health condition
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ Problem with blood not clotting
- ☐ Sleepwalking
- ☐ Swollen or painful joints
- ☐ Ulcers
- ☐ Other (Identify) _____

Are you currently taking any medication?
☐ Yes. If yes, explain on separate page.
☐ No

Are you allergic to any medication?
☐ Yes. If yes, explain on separate page.
☐ 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.

	Date of the original series (MM/DD/YYYY)	Date of last booster to ensure immunization (MM/DD/YYYY)
Tetanus, Diphtheria, Pertussis (Tdap)		
Polio Vaccine (IPV)		
Measles, Mumps, Rubella (MMR)		
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: _____ Date: _____

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To be completed by Parent/Guardian

Emergency Contact First Name | Last Name | Relationship

Address Street | City | State | Zip

Email | Phone 1 | Phone 2

Please clearly outline any medications that the applicant is taking including the name and dosage. If necessary, please also outline specific instructions for any medications that a YCC Program Staff will need to administer to the YCC Crew Member. Please use the space below or continue on page 3.

Please identify on page 3, any condition below 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 permitted)

Environmental Factors

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

I certify that I am familiar with the Youth Conservation Corps Program and that I give my consent to my son/daughter/ward to participate in 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 adaquate facility approved by the YCC.

Parent/Guardian Signature | Date (MM/DD/YYYY)

PRIVACY ACT STATEMENT FOR THE YCC MEDICAL HISTORY FORM (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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Reviewing Officer's Signature | Date (MM/DD/YYYY)

United States Youth Conservation Corps

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Additional Information

Please use this space to provide any additional information.