



TO BE COMPLETED BY APPLICANT

Last Name	First Name	Middle Name	Date of Birth (Month/Day /Year)
Home Address		Apt #	Country
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Height* Feet Inches	Weight (in Pounds) Pounds	Phone

Emergency Contact **Must speak English**

Relation to Applicant	Name	Email
Home Address	Country	Home Phone Mobile Phone

Do you have any medical condition that that requires you to have additional insurance beyond that provided by ACES? Yes No

Are you covered by a different insurance than that provided by ACES? Yes No

If you answered yes to either question above, please give details: Carrier/Plan Number: _____
Group or Policy Number: _____ Carrier Contact Phone Number: _____

Health History
(Check all that apply)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Hepatitis A/B/C	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy/ Seizures	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Malaria	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> German Measles	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Depression	<input type="checkbox"/> Glandular Fever	<input type="checkbox"/> Migraine/ Headaches	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other		

If you check any of the above, please give details (including dates) on a separate sheet of paper.

Do you suffer from any allergies? If yes, please give details including reaction and management of the reaction.

Allergies	Describe reaction:	Management or treatment:
<input type="checkbox"/> Hay Fever		
<input type="checkbox"/> Insect Sting		
<input type="checkbox"/> Penicillin		
<input type="checkbox"/> Other drugs		
<input type="checkbox"/> Other:		

Place a check mark next to following organs or systems if there any known abnormalities? If you check any of these please explain in detail:

<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Head, ears ,nose, throat	<input type="checkbox"/> Reproductive	<input type="checkbox"/> Metabolic
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Eyes (including glasses or contacts)	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Skin
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Nervous	<input type="checkbox"/> Other

Have you ever undergone surgery? Yes No If yes, please give full details of operations and dates on a separate sheet of paper.

General Questions

Is your physical activity restricted in any way? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any dietary restrictions? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any chronic or reoccurring illness? <input type="checkbox"/> Y <input type="checkbox"/> N	Are you currently taking any medicines? <input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever been treated by a psychiatrist? <input type="checkbox"/> Y <input type="checkbox"/> N		Have you ever received treatment for a nervous or emotional issue? <input type="checkbox"/> Y <input type="checkbox"/> N	

If you answered yes to any of these please give full details including the medicines that you will be taking at camp on a separate sheet of paper.

I certify that all information given is true to the best of my knowledge, and I hereby give permission for emergency medical care to be taken place should it be needed.

Signature _____ Date _____

Print Name _____

TO BE COMPLETED BY PHYSICIAN

As an Exchange Visitor in the U.S., the below referenced applicant will be living with and responsible for young children. It is therefore important that we are advised of any physical or mental health problems that may have a bearing on the applicant's ability to participate.

Applicant

Last Name	First Name	Date of Birth (Month/Day/Year)
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Please review the information provided by the applicant on Page 1 of this form and answer the following questions.

The above named applicant is in good physical condition. Yes No

The above named applicant does NOT have any physical or emotional issues that would negatively affect his/her work as a camp counselor/support staff at a US summer camp. Yes No

Comments:

Please check whether the applicant had been immunized against the following and provide the date of immunization:

<input type="checkbox"/> Chicken Pox (Varicella) Date	<input type="checkbox"/> Hepatitis B Date	<input type="checkbox"/> TP Mantoux test Date	<input type="checkbox"/> Diphtheria Date
<input type="checkbox"/> Haemophilus InfluenzaeB Date	<input type="checkbox"/> Tetanus Date	<input type="checkbox"/> Mumps Date	<input type="checkbox"/> Typhoid Date
<input type="checkbox"/> German Measles (Rubella) Date	<input type="checkbox"/> Measles Date	<input type="checkbox"/> Polio Date	<input type="checkbox"/> Whooping Cough Date
Name of Doctor		Street Address	
Country	Signature		Date (Month/ Day/ Year) / /
Telephone number (with country and city codes)		Email:	