



**UNITED STATES YOUTH CONSERVATION CORPS
MEDICAL HISTORY FORM**



To be Completed by Youth Conservation Corps (YCC) Program Applicants Only

NOTE: This information is collected under the authority of Public Law 93-408. It will be used primarily for the purpose of determining your eligibility for Youth Conservation Corps service. **Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Youth Conservation Corps member.**

APPLICANT MEDICAL HISTORY

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

Name:

First: Middle Last Suffix

Gender: Male Female

Date of Birth: mm/dd/yyyy ____/____/____ Age _____

Contact Information

Address:

Street City State Zip

Email: Phone 1 Phone 2

Are you covered under your family or any other type of health insurance?

Yes No If yes, name of insurer and policy number

Primary Care Provider Name:

Address:

Have you had or are you having any of the following health conditions? (Enter X where appropriate and describe on page 3.)

Allergies	Frequent Infection	Other health condition
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Cold	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Loss of weight
<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Earache	<input type="checkbox"/> Lyme disease
<input type="checkbox"/> Insect stings	<input type="checkbox"/> Bladder or Intestinal infection	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Skin condition	<input type="checkbox"/> Intestinal infection	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Skin condition	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Convulsion	<input type="checkbox"/> Sleepwalking
	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Swollen/painful joints
	<input type="checkbox"/> Difficulty with balance	<input type="checkbox"/> Mental Health Conditions
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart Condition
	<input type="checkbox"/> Problem with blood not clotting	
Other (identify)		

Are you currently taking any medications?

Yes – if yes, explain on page 2
 No

Are you allergic to any medications?

Yes – if yes, explain on page 2
 No

Immunization history – *Enter X where appropriate and dates as indicated. A Tdap shot is required unless you have received one or a booster within the last ten years. **You may attach a copy of your immunization record as a separate document*** Check here if immunization records are attached as a separate document.

Date of Series mm/dd/yyyy	Date of Last Booster to Ensure Immunization mm/dd/yyyy
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- Tetanus Toxoid, Diptheria, 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

Applicant Name	Applicant Signature	Date
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Medical and Physical Abilities and Limitations

The requested below will be kept strictly confidential and safeguarded. This information will only be disclosed in accordance with the requirements of the Department of Labor’s regulations and other applicable federal laws.

- Please use the table below to identify any medication(s) that the applicant is currently taking. Include the name, dosage and any specific instructions that a YCC Program Staff would need to administer medication (if necessary).

Medication Name	Dosage	Instructions

Allergic to which medications

- Below is a list of typical activities and environmental factors required for outdoor work. Please check any of the items below that may limit full participation in the YCC program.

Physical and functional Requirements

- | | | |
|---|--|---|
| <input type="checkbox"/> Heavy lifting, 45 pounds and over | <input type="checkbox"/> Use of fingers | <input type="checkbox"/> Repeated bending |
| <input type="checkbox"/> Heavy carrying, 45 pounds and over | <input type="checkbox"/> Use of both hands | <input type="checkbox"/> Climbing, legs only |
| <input type="checkbox"/> Straight pulling | <input type="checkbox"/> Walking | <input type="checkbox"/> Climbing, use of legs and arms |
| <input type="checkbox"/> Pulling hand over hand | <input type="checkbox"/> Standing | <input type="checkbox"/> Use of both legs |
| <input type="checkbox"/> Pushing | <input type="checkbox"/> Crawling | <input type="checkbox"/> Hearing (aid permitted) |
| <input type="checkbox"/> Reaching above shoulder | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Corrected vision in one eye (20/20 to 20/40) |

Environmental Factors

- | | | |
|---|--|--|
| <input type="checkbox"/> Outside | <input type="checkbox"/> Dry atmospheric conditions | <input type="checkbox"/> Working around moving objects |
| <input type="checkbox"/> Excessive heat | <input type="checkbox"/> Excessive or intermittent noise | <input type="checkbox"/> Working on ladders or scaffolding |
| <input type="checkbox"/> Excessive cold | <input type="checkbox"/> Dust | <input type="checkbox"/> Working with hands in water |
| <input type="checkbox"/> Excessive humidity | <input type="checkbox"/> Slippery or uneven walking surfaces | <input type="checkbox"/> Working closely with others |
| | | <input type="checkbox"/> Working alone |

Please use this space to identify any of the conditions listed above that would restrict full participation or require special care or treatment,

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN OF THE APPLICANT

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 non-program 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.

Name

Parent/Legal Guardian Name Parent/Legal Guardian Signature Date

Address:

Street City State Zip

Contact Information

Email Emergency Contact Number #1 Emergency Contact Number #2

TO BE COMPLETED BY REVIEWING OFFICER

Reviewing Officer's Name Reviewing Officer's Signature Date

Additional Information. Please use this space to provide any additional information needed to complete the application.

NOTICES

PRIVACY ACT STATEMENT

Authority: 16 USC 1701-1706, Chapter 37 – Youth Conservation Corps and Public Lands Corps, Subchapter I – Youth Conservation Corps (Youth Conservation Corps Act of 1970 (P.L. 91-378; 84 Stat. 794) as amended in 1972 (P.L. 92-597) and in 1974 (P.L. 93-408).

Purpose: This information is collected from selected applicants to determine their ability to fully participate, and to allow the participating agencies to make necessary reasonable accommodations as appropriate.

Routine Uses: The information collected on this form may be shared in accordance with the Privacy Act of 1974 and the routine uses listed in the DOI Office of the Secretary (OS) System of Records Notices INTERIOR/OS-25, YCC Enrollee Records available at <https://www.doi.gov/privacy/os-notices>.

Disclosure: Furnishing this information is voluntary; however, failure to provide the requested information may disqualify acceptance into the YCC program.

PAPERWORK REDUCTION ACT STATEMENT

In accordance with the Paperwork Reduction Act (44 U.S.C. 3501), the U.S. Department of the Interior, National Park Service and U.S. Fish and Wildlife Service, collects information necessary to assist the agencies in safeguarding the health, safety, and welfare of the enrollees of the YCC programs. Your response is voluntary, but failure to complete this form will result in exclusion from participation in the YCC Program. 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 currently valid OMB control number. OMB has approved this collection of information and assigned Control No. 1093-0010.

ESTIMATED BURDEN STATEMENT

We estimate public reporting for this collection of information to average 14 minutes, including time for reviewing instructions, gathering and maintaining data and completing and reviewing the form. Direct comments regarding the burden estimate or any other aspect of the form to the Departmental Information Clearance Officer, U.S. Department of the Interior, 1849 C Street, NW Washington, DC 20240, or via email at doi-pra@ios.doi.gov. Please do not send your completed form to this address.