



**Medical History Form**  
 701 Rainbow Blvd Salida, CO 81201  
 719-539-2438 Fax 719-539-2483 www.sccorps.org

<b>Name (Last, First, Middle Initial)</b>	<b>Address (Street, City, State, Zip Code)</b>
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<b>Primary Phone</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Height</b>	<b>Weight</b>	<b>Social Security #</b>
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<b>Do you have health and accident insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Insurance Company</b>  <b>Policy Number</b>	<b>Date of Birth</b> (mm/dd/yy)
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In the event of an emergency SCC staff must be able to contact a designated emergency contact. Please provide at least one primary phone number for each contact. (Under 18 *MUST* Include Parent or Legal Guardian)

<b>Primary Contact:</b>	<b>Secondary Contact:</b>	<b>Third Contact:</b>
Name: _____	Name: _____	Name: _____
Relationship: _____	Relationship: _____	Relationship: _____
City, State: _____	City, State: _____	City, State: _____
Work phone: _____	Work phone: _____	Work phone: _____
Home Phone: _____	Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____	Cell Phone: _____

<b>Do you have any of the following allergies?</b> <input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma <input type="checkbox"/> Insect Stings <input type="checkbox"/> Skin Condition <input type="checkbox"/> Certain Foods <input type="checkbox"/> Medicines <input type="checkbox"/> Other Do you require epinephrine (epi pen) to treat allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Explain if you have checked any of the above boxes:	<b>Vaccinations:</b> <input type="checkbox"/> Measles, Mumps, Rubella Date: _____ <input type="checkbox"/> Tetanus Date: _____
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<b>Are you currently under a physicians care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No What is the condition?	<b>Do you have any current medical problems?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	<b>Do you have any medical conditions that might interfere with your duties?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	<b>Have you been or are you under the care of a counselor or psychiatrist?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
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**If currently under the care of a physician, counselor, or psychiatrist please list their name address and phone number.**

**Have you been exposed to any contagious diseases in the past two weeks? If yes, explain.**

Yes  No

<b>Are you currently taking medications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Medication                      How many times a day	<b>Do you self-medicate?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Amount of Dosage
1)	
2)	
3)	

**MEDICAL HISTORY:** (Have you been treated for any of the following? Please list dates.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD                 | <input type="checkbox"/> Depression                | <input type="checkbox"/> Measeles/Mumps            |
| <input type="checkbox"/> AIDS/HIV Positive        | <input type="checkbox"/> Diabetes/Hypoglycemia     | <input type="checkbox"/> Migraine Headaches        |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Dizziness or fainting     | <input type="checkbox"/> Mononucleosis             |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Emotional Disorders       | <input type="checkbox"/> Panic Attacks             |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Pleurisy                  |
| <input type="checkbox"/> Back pain/injury         | <input type="checkbox"/> Gastric Ulcers            | <input type="checkbox"/> Polio                     |
| <input type="checkbox"/> Broken bones             | <input type="checkbox"/> Giardia                   | <input type="checkbox"/> Problems w/joints         |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Head Injury               | <input type="checkbox"/> Recurring/chronic illness |
| <input type="checkbox"/> Carpal Tunnel            | <input type="checkbox"/> Heart Condition/Disease   | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Chemical Addition        | <input type="checkbox"/> Hearing Problems/Deafness | <input type="checkbox"/> Severe Accident           |
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Thyphoid Fever            |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Thyroid Disease           |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> Contacts/Eye glasses     | <input type="checkbox"/> Knee Injury               | <input type="checkbox"/> Other, specify:           |
| <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Liver Disease             |  |
| <input type="checkbox"/> Cystitis                 | <input type="checkbox"/> Lung Disease              |  |

Surgery or hospitalization in the last 2 years, please specify:

Describe treatment/diagnosis for any indicated above:

**CORPSMEMBERS & LEADERS SHOULD READ ALL OF THE FOLLOWING INFORMATION AND SIGN BELOW.**

**HEALTH INFORMATION AUTHORIZATION**

I acknowledge that participation as a Corp Member or Crew Leader of Southwest Conservation Corp Program activities, described in the SCC Corp Member Handbook (“SCC Program”), involves potentially dangerous activities that challenge a person’s physical and mental limits, based upon the number and types of participants, terrain, temperature, weather conditions, equipment, animals, and actions of others. These risks include property damage, personal injury, mental distress, and death. I understand participation in the SCC Program demands a very high level of exertion and stamina. I know participants must be able to lift up to 50 pounds, work at high altitudes, hike long distances, carry equipment, and work in steep, rugged terrain. Because of these SCC Program conditions:

*I authorize SCC to have access to the otherwise private health information included in this form in order to assess my suitability for program participation, and to refer me to medical care if it becomes necessary.*

*I certify that I am physically fit, have sufficiently prepared for SCC Program participation, and have received no advice from a qualified medical professional not to participate in the program. I certify that there are no known health-related reasons which prevent my participation in the SCC Program. I certify SCC encouraged me to have a physical examination by a qualified health professional prior to SCC Program participation.*

**I HAVE READ THIS DOCUMENT AND I UNDERTAND IT. I SIGN IT OF MY OWN FREE WILL.**

_____ PRINTED name	_____ Age	_____ Signature (if under 18, parent or guardian must also sign)	_____ Date
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**PARENT/GUARDIAN WAIVER AND RELEASE FOR CREW MEMBERS UNDER AGE 18**

I am the parent or legal guardian of the minor child, and acting in this capacity, consent to the minor’s participation in the SCC Program, and to all terms of the waiver and release of liability stated above, which I have read and fully understand.

_____ PRINTED name of parent/guardian	_____ Signature of parent/guardian	_____ Date
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