



# Health History Form

The participant and their Doctor must complete all sections of this form. It must be completed in English as a fillable PDF or neatly hand written. Please provide as much detail as possible. Please upload this form to your Footprints account and take the original copy with you. Falsifying or failing to disclose information about your health may result in dismissal from the CCUSA program. Remember certain immunizations are REQUIRED. If you have any questions or concerns about this form, contact your local CCUSA office. If additional space is needed, please attach a separate sheet.

## PERSONAL INFORMATION - APPLICANT COMPLETE THIS SECTION

Last Name	González Montiel	First Name	Luis Fernando	Birth Date	12/Febrero/1996	Gender:	<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Female
Home Address	Acatitla	Number & Street	#31	City	Mexico City	Postal Code	10630	México
Home Phone	55 56 67 26 26	Mobile Phone	55 21 41 89 48					
Emergency Contact Name	María Dolores Montiel Delgadillo			Relationship	Mother			
Home Phone	55 56 67 26 26	Mobile	55 21 70 88 99	Work Phone	55 51 34 23 00	ext.	1029	
Alternate contact in case of emergency: Name	Aura Amaranta González Montiel			Phone	55 80 33 75 50			
Name of physician in home country								

## HEALTH HISTORY—APPLICANT COMPLETE THIS SECTION

Check all that apply and give approximate date.

Illness	Date	Diseases	Date	Allergies	
<input type="checkbox"/> Frequent ear infections		<input checked="" type="checkbox"/> Measles*	June 1997	<input type="checkbox"/> Polson Ivy/Oak/Sumac	<input type="checkbox"/> Insect stings
<input type="checkbox"/> Heart defect/disease		<input checked="" type="checkbox"/> Chicken Pox*	May 1998	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Seizures		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Penicillin	(Moderate/Severe)
<input type="checkbox"/> Diabetes		<input checked="" type="checkbox"/> Mumps*	Sep 1997	<input type="checkbox"/> Other drugs (specify) _____	
<input type="checkbox"/> Bleeding disorders		<input type="checkbox"/> Tuberculosis*	IMMUNE	<input type="checkbox"/> Food (specify) _____	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Hepatitis			
<input type="checkbox"/> Mononucleosis		<input type="checkbox"/> Bronchitis			
<input type="checkbox"/> Sinus trouble		<input type="checkbox"/> Lyme Disease			
<input type="checkbox"/> COVID-19		<input type="checkbox"/> Migraine headaches			

\*If you have not been immunized for this, then please speak to your Doctor/Medical Practitioner to ensure you obtain these vaccinations/inoculations prior to arrival.

I smoke:  Regularly  Occasionally  Socially  Never I consume alcohol:  Daily  Weekly  Seldom  Never

List surgeries or major illnesses you have had in the last 5 years (include dates):

Nothing

List chronic health concerns which might affect your ability to work. Please include any physical conditions requiring restriction(s) on participation on the program with a description of the restriction:

Nothing

If you have listed any chronic health concerns, what can your employer do to facilitate your performance?

Have you ever been under a professional's care for emotional, psychological or learning difficulties?  Yes  No If yes, when and describe.

Can you do the following, without difficulty, for an extended amount of time? Push:  Yes  No Pull:  Yes  No Walk:  Yes  No

Run:  Yes  No Bend:  Yes  No Lift:  Yes  No If No, please explain: \_\_\_\_\_

Can you physically and emotionally support children and yourself for the summer?  Yes  No

## MEDICATIONS BEING TAKEN—APPLICANT COMPLETE THIS SECTION

Please list ALL current medications including over-the-counter, prescriptions, vitamins and supplements. Bring enough medication to last your entire trip overseas. Keep it in the original packaging that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Attach additional sheet for more medications if needed.

I take medications as stated below.  I take NO medications on a routine basis.

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

## DIETARY RESTRICTIONS—APPLICANT COMPLETE THIS SECTION

<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Vegan	<input type="checkbox"/> Lactose Intolerant	<input type="checkbox"/> Gluten Free
<input type="checkbox"/> Other dietary restrictions/food allergies _____			



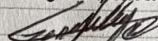
## GENERAL QUESTIONS—APPLICANT COMPLETE THIS SECTION

The following questions must be answered truthfully and to the best of your knowledge.

- |     |   |   |  |  |                              |  |
|-----|---|---|--|--|------------------------------|--|
| 1.  | Had any recent injury, illness or infectious disease? | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 15. Ever had problems with joints (e.g. knees, ankles)?  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 2.  | Have a chronic or recurring illness?                  | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 16. Have any skin problems (itching, rashes, psoriasis)? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 3.  | Ever been hospitalized?                               | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 17. Have diabetes?                                       | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 4.  | Ever had surgery?                                     | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 18. Have asthma?   | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 5.  | Have frequent headaches?                              | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 19. Had mononucleosis in the past 12 months?             | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 6.  | Ever had a head injury?                               | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 20. Had problems with diarrhea/constipation?             | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 7.  | Ever been knocked unconscious?                        | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 21. Have problems with sleepwalking?                     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 8.  | Wear glasses, contacts?                               | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            | 22. Ever had a diagnosed eating disorder?                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 9.  | Ever had frequent ear infections?                     | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 23. Ever had emotional and/or mental difficulties?       | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 10. | Ever passed out during or after exercise?             | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | If YES, did you seek professional help?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| 11. | Ever had seizures?                                    | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | If YES, did you receive medication?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |
| 12. | Ever had chest pain during or after exercise?         | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 24. Have you ever tested positive for HIV?               | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 13. | Ever had high blood pressure?                         | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | 25. Have you ever tested positive for Tuberculosis?      | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 14. | Ever had back problems?                               | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |  |                              |  |

Please explain any YES answers, noting the question number(s) above before your response. Use an additional sheet if more space is required.  
**CONTACT YOUR CCUSA REPRESENTATIVE IF YOU ANSWERED YES TO ANY OF THE ABOVE.**

I hereby certify that all information and statements contained in this Heath History Form are valid, true and correct to the best of my knowledge, in regards to my current and previous health status. I understand and agree that if this information is incorrect or I am not able to follow the health guidelines set by my employer, I risk dismissal from the CCUSA program. If a change in my health status occurs, I agree to notify CCUSA and the employer I am placed at in writing of that change immediately and prior to leaving my home country. I hereby give permission for emergency medical care to take place should it be necessary. I AUTHORIZE THE INSURANCE COMPANY or any party the company authorizes to obtain, or release any information acquired in the course of my examination or treatment. I give permission for CCUSA to contact my doctor for any additional information. If submitting this form electronically (emailing form) check the box below as an alternative to signing.

Applicant's signature 

Date **March 19<sup>th</sup>, 2022**

## IMMUNIZATION HISTORY—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

Enter the month/year of immunizations and booster date (if applicable). If multiple doses, list the date of the final dose. If unsure they have had the mandatory immunizations a "Titer Test" must be taken and results sent to CCUSA before departure.

### Vaccines

	Immunization	Booster(s)	Vaccines	Immunization	Booster(s)
DPT series* (Diphtheria, Pertussis, Tetanus)	April 1996	March 2000	Varicella (Chicken Pox) **	IMMUNE	
MMR* (Mumps, Measles, Rubella)	Immune		Small Pox		
Hepatitis A			Typhoid		
Hepatitis B			IPV* (Polio)	Feb 1996	Feb 1998
COVID-19	1 shot, IBI. June 2021				

\*Mandatory Immunizations (if expired new immunizations MUST be taken)

\*\*Only required if not immune

Has this patient ever been tested for Tuberculosis (TB)?  Yes  No If Yes - Date: \_\_\_\_\_

If No - Patient must understand that their employer may require this prior to arrival and must discuss this directly with their employer.

## MEDICAL ASSESSMENT—MUST BE COMPLETED BY A REGISTERED MEDICAL PROFESSIONAL

**Note to physician:** This program involves rigorous physical activity, long working hours, extreme weather conditions and potential stressful situations. Your assessment should be directed to the person's mental and physical fitness to engage in such a program. There is no liability associated with your recommendation of suitability.

Height **1.93m** Weight **80Kg**

Please use the following code when completing your examination: S = Satisfactory      X = Not Satisfactory      O = Not Examined

<input checked="" type="checkbox"/> Eyes	<input checked="" type="checkbox"/> Heart	<input checked="" type="checkbox"/> Lungs	<input checked="" type="checkbox"/> Ears	<input checked="" type="checkbox"/> Spine	<input checked="" type="checkbox"/> Extremities
<input checked="" type="checkbox"/> Nose	<input checked="" type="checkbox"/> Blood Pressure	<input checked="" type="checkbox"/> Teeth	<input checked="" type="checkbox"/> Skin	<input checked="" type="checkbox"/> Abdomen	<input checked="" type="checkbox"/> Throat

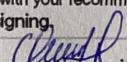
Is this person on any medications that she/he will need to take with them overseas? (Please describe):

**Does not apply**  
**Healthy, fit for physical activity.**

Please rate the overall muscular skeletal condition of this person:

Back: **Integra, fuerza conservada** Knees: **integras, sanas** Ankles: **integros, fuerza conservada**

I have examined the above CCUSA applicant and have reviewed her/his health history. It is my opinion that she/he: (check)  IS  IS NOT physically able to engage in the rigors of the program. (Please Note: There is no liability associated with your recommendation of suitability.) If submitting this form electronically (emailing form) check the box below as an alternative to signing.

Licensed Examining Physician's Signature **ced. prof. 12464594**  Date **19/03/2022**

Physician's Name (please print) **Maria Luisa Gasca Menchaca** Phone **5561662104**

Address **Av. Guerrero 2677, col. Pueblo de San Bernabe** CDMX **10300** México  
Number & Street City Postal Code Country

