AmeriCorps NCCC Medical/Mental Health Information Form

Instructions: Complete **ALL PAGES** of this form and provide your signature upon completion. This form must be returned to us no later than the date indicated on the accompanying materials. **Incomplete forms cannot be processed.** To process the required medical clearance, additional information may be required by the Medical Screening Nurse and/or Counselor.

ANSWER ALL QUESTIONS. Incomplete forms cannot be processed and may result in your removal from further consideration for NCCC service.

Part I.

Name (Last, First, Middle) _____ Date of Birth (MM/DD/YYYY) _____ Gender/Identifies as _____

MyAmeriCorps Applicant ID # _____ Height ft. in. Weight lbs Shoe Size _____

Email Address _____ Primary Contact phone number _____ Alternate phone number _____

Part II. Answer YES or NO to all questions. All NO responses must show an explanation stating "N/A". All YES responses must have explanation in the space provided or on a separate sheet, and should include dates, details of condition, treatment received, and current status.

During the last FIVE YEARS, have you…?

A. Been treated in an Emergency Room? Please provide dates, condition treated, and current status if you were treated in an ER. **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

B. Been admitted to a hospital? Provide dates, reason for treatment, and current status if you were admitted. **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

C. Been treated for ANY behavioral health conditions or mental health conditions? This includes therapy, counseling, and medications. **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

D. Tested positive for skin test (PPD) or had a chest x-ray for tuberculosis? **If NO, write "N/A"; if YES, explain** and provide proof of clear chest x-ray or completion of medication. (If not able to send with this form, proof can be sent via email or fax at a later time.)

☐ NO
☐ YES

Date(s)	Explanation

Medication List:

Please list all medications you are taking, including nonprescription drugs, vitamins, and herbal supplements.

Medication Name:	Dose and How Often	When First Precribed and Reason for Taking:

Part III. Answer YES or NO to all questions. All NO responses must show an explanation stating "N/A". All YES responses must have explanation in the space provided or on a separate sheet, and should include dates, details of condition, treatment received, and current status.

Do you now have/have you ever had…?

E. Diabetes diagnosis or treatment? **If NO, write "N/A". If YES, explain** (specify Type I or Type II, date of diagnosis, and whether you have an insulin pump).

☐ NO
☐ YES

Date(s)	Explanation

F. Diagnosed or treated for any heart condition, disease, heart murmur, chest pain (angina), palpitations (irregular beat), heart attack, heart surgery, angioplasty, or a pacemaker, valve replacement, or heart transplant? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

G. Asthma diagnosis or treatment? **If NO, write "N/A". If YES, explain** (specify how often you use your rescue inhaler, and how often you use a nebulizer).

☐ NO
☐ YES

Date(s)	Explanation

H. Arthritis; impaired use of arms, legs, feet, or hands; hip/knee/joint pain; or any bone or joint condition? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

I. History of back injury or back surgery, or any limitations that prevent you from bending, twisting, lifting, or other repetitive movements? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

J. Seizures, syncope, blackouts, or epilepsy? **If NO, write "N/A". If YES, explain** (specify the date of your last seizure, episode, or blackout).

☐ NO
☐ YES

Date(s)	Explanation

K. Permanent loss of hearing, or need to wear hearing aids? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

L. Permanent loss of vision or blindness in one or both eyes? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

M. Life-threatening allergy? **If NO, write "N/A". If YES, explain** (and indicate whether you have an EPI pen).

☐ NO
☐ YES

Date(s)	Explanation

N. Diagnosis of attention deficit disorder, ADD/ADHD? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

O. Autism, Asperger's, or a learning/processing disorder? Attach/ Explain IEP if applicable. **If NO, write "N/A". If YES,**

☐ NO
☐ YES

Date(s)	Explanation

P. Depression or anxiety? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

Q. Bulimia, Anorexia, or Eating disorder? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

R. Bi-Polar, Schizophrenia, or Paranoia? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

S. Self-mutilation or cutting? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

T. Attempted Suicide? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

U. Drug or Alcohol abuse, substance treatment, or counseling? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

V. Significant medical/mental health conditions not listed above? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

W. Do you require an accomodation to serve in NCCC? **If NO, write "N/A". If YES, explain.**

☐ NO
☐ YES

Date(s)	Explanation

X.

Are you up-to-date on all immunizations including the MMR and DTaP?

☐ NO ☐ YES

If NO →

Are you willing to receive these vaccinations upon your arrival to campus?

☐ NO ☐ YES

Part IV.

I understand it is my responsibility to notify the Medical Screening Division of any changes in this information prior to my arrival to a campus, by phone (202-606-6702) or email (NCCCmedicalscreeningunit@cns.gov).

I certify that the information disclosed in this document is true and complete to the best of my knowledge and belief. I understand that if any of the information submitted in the document is false or is an intentional omission, it may be a basis for immediate disqualification from the program.

Applicant Signature

Date Signed

This form must be signed in order to be complete. Unsigned forms cannot be processed.

PRIVACY ACT NOTICE: Information is requested pursuant to 42 U.S.C.§12615(b). Purpose is to determine whether the medical/mental health history and identifiable health risks of individual members will allow them to perform the essential functions of AmeriCorps NCCC participants with or without reasonable accommodation. Because AmeriCorps NCCC operates a residential program that requires members to engage in activities with varying requirements, it is important to know the medical/mental health history of the individual and whether they are qualified to perform the essential functions of an AmeriCorps NCCC member. Information is confidential, for official use only, and will only be released to personnel on a need-to-know basis. Disclosure of this information is voluntary, yet failure to submit this completed form may result in the individual's disqualification from further processing.