



# MEDICAL DISCLOSURE

APPLICANT'S NAME:..... MEMBERSHIP NUMBER: \_ \_ \_ \_ \_

1. Name of medical condition, including a brief description of the main symptoms: .....

2. For anyone enclosing a history of depression / eating disorder / overdose / Obsessive Compulsive Disorder, please describe what you understand to be the reasons this first occurred: .....

3. Please describe any effects your medical condition has on your daily life (please include any limitations): .....

4. Are you currently taking medication for this condition? Yes / No (If 'No' go to question 5)

- a) Name of medication: .....
b) How often do you take this medication? .....
c) Do you experience any side effects with this medication? Yes / No
d) If 'Yes' please detail: .....
e) How long do you expect your medication to continue? .....

5. Are you currently an outpatient at a hospital? Yes / No

6. When did your doctor first diagnose this condition? ..... (month) ..... (yr)

- a) At the time of diagnosis were you prescribed medication? Yes / No
b) If 'Yes' please detail (including dates, name of medication and when medication was used) .....
c) If you are no longer taking medication when was it last prescribed to you? ..... (month) ..... (yr)
d) Have you suffered from this condition in the last 12 months? Yes / No

ii) If 'Yes' how frequently has the condition occurred: weekly [ ] monthly [ ] 6 monthly [ ] Other: [ ] .....

iii) How often do you see your doctor regarding this condition?

weekly  monthly  6 monthly  Other:  .....

7. Are there any factors that are likely to cause a reoccurrence? Yes / No

If 'Yes' please detail: .....

.....

8. Are there any special considerations that need to be made for this condition (ie special equipment / allergy free environment)? .....

.....

9. When did the condition end? ..... (month) ..... (yr)

10. When was the last time you saw your doctor regarding this condition? .....

.....

11. Have you ever been admitted to hospital in relation to this condition? Yes / No

If 'Yes' please detail when and how long you were in hospital: .....

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**PLEASE NOTE: CAMP AMERICA INSURANCE DOES NOT COVER PRE-EXISTING CONDITIONS OR ANY ASSOCIATED MEDICATION**

I hereby confirm that I have completed this form fully and honestly, and that all the information above is correct. I gave Camp America permission to discuss this matter further with my doctor. I understand that non-disclosure of my full medical condition will result in cancellation from the programme and forfeiture of all payments made to Camp America.

SIGNATURE ..... DATE .....

DOCTOR'S NAME AND ADDRESS: .....

.....

.....

DOCTOR'S TELEPHONE NUMBER: .....

FOR INTERVIEWER USE ONLY

INTERVIEWER NAME:..... INTERVIEWER NUMBER: \_ \_ \_ \_ \_

Is a medical note required? Yes / No

If 'Yes' is the medical note attached? Yes / No

If 'No' is the applicant obtaining a medical note? Yes / No

If the applicant has a serious condition, please state the name of the staff member in the London office who has given you authorisation to interview: .....