

Runner's Workshop Inc.
CAMP HEALTH HISTORY AND EXAMINATION FORM

NAME _____ Camp Attending _____ BIRTH DATE _____ SEX ____ AGE ____

PARENT OR GUARDIAN _____ PHONE _____

HOME ADDRESS _____

BUSINESS ADDRESS _____ PHONE _____

SECOND PARENT OR GUARDIAN CONTACT: _____

HOME ADDRESS _____ PHONE _____

BUSINESS ADDRESS _____ PHONE _____

IF NOT AVAILABLE IN EMERGENCY, NOTIFY:

NAME _____ PHONE _____

ADDRESS _____

HEALTH HISTORY: (CHECK-GIVING APPROXIMATE DATES)

FREQUENT EAR INFECTIONS _____
HEART DEFECT/DISEASE _____
CONVULSIONS _____
DIABETES _____
BLEEDING/CLOTTING DISORDERS _____
HYPERTENSION _____

ALLERGIES
HAY FEVER _____
IVY POISONING _____
INSECT STINGS _____
PENICILLIN _____
OTHER DRUGS _____

OPERATIONS OR SERIOUS INJURIES (DATES): _____

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN'S ADVICE: _____

DIETARY MODIFICATIONS: _____

CURRENT MEDICATION (SEND WITH INSTRUCTIONS): _____

NAME OF FAMILY PHYSICIAN: _____ PHONE _____

DATE OF LAST TETANUS SHOT: _____

DO YOU CARRY MEDICAL/HOSPITAL INSURANCE? _____ CARRIER: _____ POLICY# _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for named above. This form may be photocopied for use out of camp.

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of parent or guardian _____ Date _____

Signature of minor _____ Date _____

HEALTH EXAMINATION BY LICENSED PHYSICIAN:

I HAVE EXAMINED THE ABOVE CAMP APPLICANT.

IN MY OPINION, THE ABOVE'S CONDITION DOES_____/DOES NOT_____/PRECLUDE HIS/HER PARTICIPATION IN AN ACTIVE CAMP PROGRAM.

THE APPLICANT IS UNDER THE CARE OF A PHYSICIAN FOR THE FOLLOWING CONDITION (S):

CURRENT TREATMENT (INCLUDE CURRENT MEDICATIONS):_____

EXPLANATION OF ANY REPORTED LOSS OF CONSCIOUSNESS, CONVULSION, OR CONCUSSION:_____

DOES APPLICANT HAVE EPILEPSY? YES___ NO___ DOES APPLICANT HAVE DIABETES? YES___ NO___

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

ANY TREATMENT TO BE CONTINUED AT CAMP:_____

ANY MEDICATION TO BE ADMINISTERED AT CAMP (SPECIFIC DOSAGES):_____

ANY MEDICALLY PRESCRIBED MEAL PLAN OR DIETARY RESTRICTIONS:_____

ANY ALLERGIES (FOOD, DRUGS, PLANTS &INSECTS, ETC.):

ADDITIONAL HEALTH INFORMATION:

LICENSED PHYSICIAN'S SIGNATURE_____PHONE_____

ADDRESS_____

DATE OF FORM COMPLETION_____.