Runner's Workshop Inc.

CAMP HEALTH HISTORY AND EXAMINATION FORM

NAME_____ Camp Attending_____ BIRTH DATE_____ SEX___ AGE___

PARENT OR GUARDIAN_____ PHONE_____

HOME ADDRESS_____ Cell Phone_____

BUSINESS ADDRESS _____ PHONE_____

SECOND PARENT OR GUARDIAN CONTACT: _____

HOME ADDRESS_____

PHONE_____ CELL PHONE_____

IF NOT AVAILABLE IN EMERGENCY, NOTIFY:

NAME_____ PHONE_____

ADDRESS_____

HEALTH HISTORY: (CHECK-GIVING APPROXIMATE DATES)

FREQUENT EAR INFECTIONS _____	ALLERGIES _____
HEART DEFECT/DISEASE _____	HAY FEVER _____
CONVULSIONS _____	IVY POISONING _____
DIABETES _____	INSECT STINGS _____
BLEEDING/CLOTTING DISORDERS _____	PENICILLIN _____
HYPERTENSION _____	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_____.