

North Cypress Running Club

Cross Country Preparation Camp

June 15 – August 7, 2010

CAMP MEDICAL FORM

Please return complete form with application and Fee.

Please print or type. All information is requested to assist us in identifying appropriate care for participants and is confidential.

Name: _____ Birth date: _____ Gender: Male ___ Female ___

Social Security Number: _____ Grade in school in 2010-11 ___ Age _____

Parent or guardian _____

Home address _____ Phone Number _____

Emergency contact: _____ Phone Number: _____

Health History

Check all that apply.

- ___ Frequent ear infections
- ___ Heart defect / Disease
- ___ Convulsions
- ___ Diabetes
- ___ Bleeding/Clotting disorder
- ___ Hypertension
- ___ Mononucleosis

Diseases

- ___ Chicken Pox
- ___ Measles
- ___ German Measles
- ___ Mumps

Allergies

- ___ Hay Fever
- ___ Ivy Poisoning, etc.
- ___ Insect Stings
- ___ Penicillin
- ___ Other Drugs
- ___ Asthma
- ___ Other (specify) _____

Date of last tetanus Shot

Name of Family Doctor _____ Phone _____

Name of Family Dentist _____ Phone _____

Do you carry family medical or hospital insurance? No ___ Yes ___

Carrier _____ Policy/Group No. _____

Is participant currently taking any medications? No ___ Yes ___

(If yes, list all on back.)

Operations or series injuries (dates) _____

Chronic or recurring illness or medical condition _____

Activities encouraged or limited by physician _____

Dietary restrictions _____

Additional health information _____

For Female

Has this person menstruated? No ___ Yes ___

If not, has she been told about it? No ___ Yes ___

If so, is her menstrual history normal? No ___ Yes ___

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. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide and arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent or guardian _____ Date _____

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

Signature of camper _____

Date _____