

RON BURTON TRAINING VILLAGE

MEDICAL FORM

NAME: _____
DATE OF BIRTH: _____ AGE: _____
PARENT OR GUARDIAN: _____
ADDRESS: _____
HOME PHONE: _____
BUSINESS ADDRESS: _____
BUSINESS PHONE: _____

EMERGENCY NOTIFICATION:

1. _____ PHONE: _____
2. _____ PHONE: _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING; (PLEASE CIRCLE)

ASTHMA	YES	NO	MONONUCLEOSIS	YES	NO
FAINTING SPELL	YES	NO	CONVULSIONS	YES	NO
PNEUMONIA	YES	NO	HEART MURMUR	YES	NO
HEART DISEASE	YES	NO	HEPATITIS	YES	NO
KIDNEY DISEASE	YES	NO	BRONCHITIS	YES	NO
RHEUMATIC FEVER	YES	NO	BLOOD DISORDER	YES	NO
DIABETES	YES	NO	HEART STROKE	YES	NO
MAJOR DENTAL PROBLEMS	YES	NO	HEAT EXHAUSTION	YES	NO
ANY SERIOUS ILLNESS OR HOSPITALIZATIONS				YES	NO

PLEASE EXPLAIN ANY POSITIVE ANSWERS.

ANY CHRONIC OR RECURRING ILLNESS? _____

DOES YOUR CHILD HAVE AN ABSENT OR IMPAIRED ORGAN? YES NO

PLEASE EXPLAIN. _____

PLEASE LIST YOUR INSURANCE CARRIER. _____

POLICY # _____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

WHEN WAS THE LAST TIME YOUR CHILD SAW HIS PHYSICIAN AND FOR WHAT REASON?

PLEASE LIST ALL OF THE MEDICATIONS YOUR CHILD IS TAKING WITH WRITTEN INSTRUCTIONS.

DOES YOUR CHILD WEAR GLASSES OR CONTACT LENSES? _____

HAS YOUR CHILD HAD A TETANUS SHOT BOOSTER IN THE LAST TEN YEARS? _____

IF SO, PLEASE LIST THE DATE IF KNOWN. _____

PERTINENT FAMILY MEDICAL HISTORY:

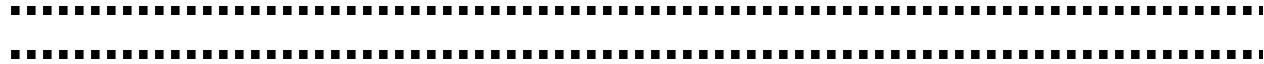
(PARENTS NOTE TO CAMP DIRECTOR:) _____

RON BURTON TRAINING VILLAGE

PARENT'S AUTHORIZATION: THIS HEALTH RECORD IS CORRECT TO THE BEST OF MY KNOWLEDGE. THE CAMPER DESCRIBED HERE HAS MY PERMISSION TO ENGAGE IN ALL ACTIVITIES EXCEPT THOSE NOTED BY ME OR THE PHYSICIAN. I AUTHORIZE ANY TREATMENT MEDICAL FACILITY AND/OR PHYSICIAN, TO TREAT, HOSPITALIZE, PERFORM TESTS, X-RAY, PERFORM SURGERY, INCLUDING ANESTHESIA OR INJECTION OR ANY OTHER PROCEDURE REQUIRED. I INDEMNIFY AND HOLD BLAMELESS **RON BURTON TRAINING VILLAGE INC. AND CAMELOT CAMP INC.**, BOSTON RED SOX AND ALL OF THEIR RESPECTIVE AGENTS AND AFFILIATES FREE FROM ANY LIABILITY OR CLAIMS RESULTING FROM SUCH TREATMENT FOREVER.

SIGNATURE: _____
Signature of Parent or Guardian

DATE: _____



MEDICAL EXAMINATION:

CODE V=SATISFACTORY X= NOT SATISFACTORY 0= NOT EXAMINED

HEIGHT _____ WEIGHT _____ HCT/HGB _____ U/A _____

EYES _____ LUNGS _____

GLASSES _____ ABDOMEN _____

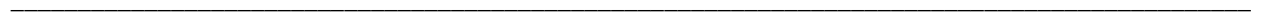
EARS _____ HERNIA _____

NOSE _____ EXTREMITIES _____

THROAT _____ SPINE/POSTURE _____

HEART _____ SKIN _____

GENITALIA _____ GENERAL APPRAISAL: _____



I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED THE HEALTH HISTORY. IT IS MY OPINION THAT THIS PERSON IS PHYSICALLY ABLE TO ENGAGE IN SUPERVISED EXTRACURRICULAR ACTIVITIES AND THOSE ACTIVITIES AT THE NEW ENGLAND SPEED & RECEIVER CAMP EXCEPT THOSE NOTED.

SIGNATURE: _____
Signature of Examining Physician

DATE: _____

*****MANDATORY**

MASSACHUSETTS STATE LAW REQUIRES THAT WE HAVE ON RECORD A COPY OF THIS CHILD'S IMMUNIZATION RECORD. PLEASE ATTACH RECORD TO THIS FORM.