BOSTON RED SOX
CHILDREN'S RETREATS

BOSTON RED SOX CHILDREN'S RETREATS - 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.
____

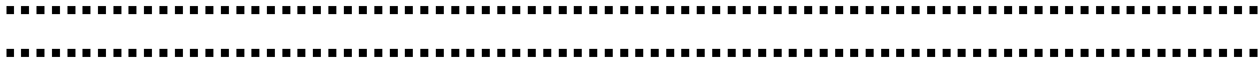
____
DOES YOUR CHILD WEAR GLASSES OR CONTACT LENSES? ______________________________
HAS YOUR CHILD HAD A TETANUS SHOT BOOSTER IN THE LAST TEN YEARS? ___________
IF SO, PLEASE LIST THE DATE IF KNOWN. ______________________

PERTINENT FAMILY MEDICAL HISTORY:
____

(PARENTS NOTE TO CAMP DIRECTOR:) ____

PARENTS 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, PHYSICIAN TO TREAT, HOSPITALIZE, PERFORM TESTS, X-RAY, PERFORM SURGERY, INCLUDING ANESTHESIA OR INJECTION OR ANY OTHER PROCEDURE REQUIRED. I INDEMNIFY AND HOLD BLAMELESS **ACTION FITNESS INC., CAMELOT CAMP, BOSTON RED SOX CHILDREN'S RETREATS** AND **RON BURTON TRAINING VILLAGE** AND ALL OF ITS AGENTS AND AFFILIATES FREE FROM ANY LIABILITY OR CLAIMS RESULTING FROM SUCH TREATMENT FOREVER.

SIGNATURE: _____________________________________ 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 BOSTON RED SOX CHILDREN'S RETREATS EXCEPT THOSE NOTED.

SIGNATURE: ____ DATE: ____________________

***<u>**MANDATORY**</u>

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