



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:) _____

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 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 RON BURTON TRAINING VILLAGE CAMP EXCEPT THOSE NOTED.

SIGNATURE: _____

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.