

HAWK HARRIER CROSS COUNTRY CAMP
MEDICAL FITNESS FORM

THIS INFORMATION IS STRICTLY FOR THE USE OF THE CAMP MEDICAL STAFF AND WILL NOT BE RELEASED.

PERSONAL INFORMATION—(Please complete this section before going to your physician)

Name: _____ Sex: _____ Age: _____

Home Address: _____
(street) (city) (state)

Parent's Name(s) _____

Home Phone #: _____ Parent's Business Phone #: _____

List any surgery you've had: _____

List all allergies: _____

Have you ever had: Head Injury _____ Heart Murmur _____
 Asthma _____ High Blood Pressure _____ Dizziness _____

Special Information: _____

I give permission for my child to receive emergency treatment at our nearby hospital.

Insurance Company: _____

Policy #: _____

Signature of Parent or Guardian

PHYSICIAN'S REPORT

Date of last Tetanus Immunization: _____

Are there abnormalities of the following systems?: Head _____ Ears _____

 Nose _____ Throat _____ Cardiovascular _____

 Eyes _____ Musculoskeletal _____ Skin _____ Hernia _____

GENERAL COMMENTS: _____

Limitation on physical activity: _____

Special Recommendation(s): _____

Is the patient under treatment for any medical or emotional condition? _____

Physician's Signature: _____ Date: _____

Address: _____ Phone #: _____