



CRI Summer Program Health Form

The health form is kept confidential and used by our health services staff (or emergency medical personnel). **Each rower must submit a completed health form or your medical provider's health form to participate in a summer rowing program. Please fill out this form as completely as possible.**

SECTION I – BASIC CONTACT INFORMATION

Name

Birth date LAST / / FIRST Age MIDDLE Gender: Male Female

Home Address

Home Phone STREET CITY STATE ZIP

Parent/Guardian #1 Name

Relationship:

Day Phone

Day Phone is Home Work Cell

Night Phone

Night Phone is Home Work Cell

Parent/Guardian #2 Name

Relationship:

Day Phone

Day Phone is Home Work Cell

Night Phone

Night Phone is Home Work Cell

Additional Emergency Contact Relationship

(In case we can't reach YOU)

Day Phone

Day Phone is Home Work Cell

Night Phone

Night Phone is Home Work Cell

Family Physician Name Phone

Dentist/Orthodontist Name Phone

SECTION II – INSURANCE INFORMATION

Is the rower covered by family medical/hospital insurance? Yes No

If yes, indicate Insurance Carrier

Group # Policy #

Policy Holder's Name Relationship to participant

SECTION III – MEDICATIONS

Will rower be taking medications while at CRI? Yes No (Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If athlete will be taking medications while at CRI, we must secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (if over 18) or administered by Health Services Staff. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians’ phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at CRI, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical devices self-administered. (Age 18 and above only.)
_____ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication _____ Dosage _____ Take at what times _____
Reason for Taking _____
Prescribing Physician _____ Phone _____

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Prescribing Physician _____ Phone _____

SECTION IV – ALLERGIES

Does rower have any allergies? Yes _____ No _____

If yes, please indicate what rower is allergic to:

- 1. Hay Fever 2. Poison Ivy/Oak 3. Insect Stings 4. Food 5. Penicillin 6. Other Drugs 7. Other
- List allergy. Describe reaction and treatment

SECTION V – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether rower has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus). _____
Tetanus Booster _____
Polio. _____
MMR (Measles, Mumps, Rubella). _____
HIB (Haemophilus Influenza B). _____
Tuberculin Test _____
Varicella (Chicken Pox). _____
Hepatitis B _____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to CRI health staff. The more information you provide, the better we can do our job. Thanks!

Does the rower have a history of or is prone to any of the following? (Please check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> 1. Recent injury, illness or infectious disease | <input type="checkbox"/> 10. Hypertension | <input type="checkbox"/> 21. Fractures |
| <input type="checkbox"/> 2. Chronic or recurring illness | <input type="checkbox"/> 11. Bleeding/Clotting Disorders | <input type="checkbox"/> 22. Frequent Headaches |
| <input type="checkbox"/> 3. Asthma | <input type="checkbox"/> 12. Diabetes | <input type="checkbox"/> 23. Head Injury |
| <input type="checkbox"/> 4. Homesickness | <input type="checkbox"/> 13. Mononucleosis (in last 12 months) | <input type="checkbox"/> 24. Eating Disorder |
| <input type="checkbox"/> 5. Frequent Ear Infections | <input type="checkbox"/> 14. Chicken Pox | <input type="checkbox"/> 25. Diarrhea or constipation |
| <input type="checkbox"/> 6. Seizure Disorder or Convulsions | <input type="checkbox"/> 15. Measles | <input type="checkbox"/> 26 Frequent Stomachaches |
| <input type="checkbox"/> 7. Dizziness during or after exercise | <input type="checkbox"/> 16. German Measles | <input type="checkbox"/> 27 Wears glasses or contacts |
| <input type="checkbox"/> 8. Chest pain during or after exercise | <input type="checkbox"/> 17. Mumps | <input type="checkbox"/> 28 Been Hospitalized |
| <input type="checkbox"/> 9. Heart Defect/Disease | <input type="checkbox"/> 18. Tuberculosis | <input type="checkbox"/> 29 Wears a Medic Alert ID |
| | <input type="checkbox"/> 19. Hepatitis | |
| | <input type="checkbox"/> 20. Joint problems (knees, ankles) | |

Please list the number and provide explanation for any checked items

Date of Last Physical Exam (Recommended within 12 months) _____

Physical Activities to be Limited or Restricted while at CRI

SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to CRI staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X _____ Date _____

V.6.2019