

# HAWK ROWING CAMP

## MEDICAL INFORMATION FORM

CAMPER'S NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

PHONE # \_\_\_\_\_

If an emergency arises, list 2 people who can be notified:

NAME \_\_\_\_\_

NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

PHONE # (HOME) \_\_\_\_\_

PHONE # (HOME) \_\_\_\_\_

(WORK) \_\_\_\_\_

(WORK) \_\_\_\_\_

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DOES THE CAMPER HAVE ANY KNOWN **ALLERGIES** TO ANY FOOD OR MEDICATION?

YES  
If yes, please list the food and/or medication

NO

Give the date of the latest DPT or Tetanus Toxoid Injection. \_\_\_\_\_

(If latest injection exceeds seven years, we recommend an injection prior to camp)

Does camper have any ongoing disease, physical disability, or recurring illness that may affect or impair his participation?  Yes  No

**If yes, please attach a physician's note describing the disability and specific limitation for participation.**

Is the camper covered by medical insurance?  Yes  No

If yes, please list the following:

Name of Company \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_