SPRINGFIELD WRESTLING SCHOOL

HEALTH/MEDICAL INFORMATION FORM

Name of wrestler:_____Date of Birth:_____

Gender: (Circle one) Male Female

Parents/Guardians that live with child (first emergency contacts)

1. Name:_____ Relation to child:_____

   Work Phone:_____ Home Phone:_____

2. Name:_____ Relation to child:_____

   Work Phone:_____ Home Phone:_____

Additional Emergency contacts

1. Name:_____ Relation to child:_____

   Work Phone:_____ Home Phone:_____

2. Name: _____Relation to child:_____

   Work Phone:_____ Home Phone:_____

HEALTH HISTORY

The following information must be filled in by the parent/guardian of the participant. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Allergies: List all known medication, food and other allergies including hay fever, insect stings, asthma, etc. Describe reaction and management of reaction.

_____ _____

_____ _____

_____ _____

_____ _____

Medications being taken:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes medications on a routine basis. (circle one) YES NO

If yes, this person takes medications as follows:

Med #1 Dosage Specific times taken each day

Reason for taking

Med #2 Dosage Specific times taken each day

Reason for taking

Med #3 Dosage Specific times taken each day

Reason for taking

Attach additional pages for more medications.

Identify any medications taken during the school year that the participant does/may not take during the summer_____

General Questions: (Explain "yes" answers below.)

Has/does the participant:	**Yes**	**No**		**Yes**	**No**

1	Had any recent injury, illness or infectious disease?	____	____	23. Had mononucleosis in the past 12 months?	____ ____
2.	Have a chronic or recurring illness/condition	____	____		
3.	Ever been hospitalized?	____	____	24. Had problems with diarrhea/constipation?	____ ____
4.	Ever had surgery?	____	____	25. Have problems with sleepwalking?	____ ____
5.	Have frequent headaches?	____	____	26. If female, have an abnormal menstrual history?	____ ____
6.	Ever had a head injury?	____	____	27. Have a history of bed wetting?	____ ____
7.	Ever been knocked unconscious?	____	____	28. Ever had an eating disorder?	____ ____
8.	Wear glasses, contacts or protective eye wear?	____	____	29. Ever had emotional difficulties for which professional help was sought?	____ ____
9.	Ever had frequent ear infections?	____	____		
10.	Ever passed out during or after exercise?	____	____	30. Have a bleeding/clotting disorder?	____ ____
11.	Ever been dizzy during or after exercise?	____	____	31. Has the child ever had any of the following diseases? (please give dates where applicable)	____ ____
12.	Ever had seizures/convulsions ?	____	____		
13.	Ever had chest pain during or after exercise?...	____	____		
14.	Ever had high blood pressure?	____	____		
15.	Ever been diagnosed with a heart murmur/defect?	____	____	**Dates**	
16.	Ever had back problems?	____	____	Chicken pox	____ ____
17.	Ever had problems with joints (e.g., knees, ankles)?	____	____	German measles	____ ____
18.	Have an orthodontic appliance being brought to camp?	____	____		
19.	Have any skin problems (e.g., itching, rash, acne)?	____	____	Mumps	____ ____
20.	Have diabetes?	____	____		
21.	Have asthma?	____	____	Measles	____ ____
22.	Have any dietary restrictions?	____	____		
				Hepatitis (A,B,or C)	____ ____

Please explain any "yes" answers noting the number of the questions.

_____

_____

_____

_____

_____

INSURANCE AND PHYSICIAN INFORMATION

Child's Medical Insurance Carrier:_____

Policy/Group Number:_____

Name of policy holder:_____Relationship to participant:_____

Social Security number of policy holder or insurance ID number:_____

Name of Dentist/Orthodontist:_____Phone:_____

Name of Family Physician:_____Phone:_____

******Please Include a Copy of the wrestler's recent physical exam (within last two years) with doctor's signature and immunization form when returning this form. This will help registration process go more smoothly******

General Appraisal:

Is camper capable of participating in an active wrestling school program? (please circle)

YES NO

Please explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

Use this space to provide any additional Information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

Parent/Guardian Authorization:

I understand and certify that my child's participation in the Springfield Wrestling School and its activities is completely voluntary and I have familiarized myself with the program and activities in which my child will be participating.

I recognize that certain hazards and dangers are inherent in this program and I acknowledge that although the Springfield Wrestling School and Springfield College have taken safety measures to minimize the risk of injury to school participants, the Springfield Wrestling School and Springfield College cannot insure or guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents, and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by the school's rules, regulations and procedures for the safety of school participants. The health history for my child is correct and he/she has permission to engage in all camp activities except as noted by me and/or the examining physician.

I hereby give permission to the health care consultant or supervisor selected by the School Director to provide routine health care, administer prescribed medicine, and seek emergency medical treatment including ordering x-rays, and routine tests for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the School Director to hospitalize, charge my health insurance, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named on the school application/registration form.

Students name:_____

Parent/guardian signature:_____

Please print name:_____Date:_____

Witness signature:_____

Please print name:_____Date:_____

I also understand and agree to abide by any restrictions placed on my participation in Springfield Wrestling School Activities:

Signature of Participant:_____ Date:_____