



# EVERGREEN ROWING CAMP

## MEDICAL HISTORY

This form must be complete in **FULL**, including signature of a physician, and **presented at check-in –DO NOT MAIL OR FAX THIS FORM IN**. A copy of a camper’s school physical, including **IMMUNIZATION HISTORY** and a **DOCTOR’S SIGNATURE**, may be substituted in lieu of this form if the physical was performed within 12 months prior to the camp start date. Campers will **NOT BE ALLOWED** to participate without signing the online Parent Release and completing the Medical History in full. If attending multiple camps, please make copies of both forms and bring a separate copy to each check in.

Camp Name: \_\_\_\_\_ Date(s) of Camp: \_\_\_\_\_

Camper’s Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Medical History (please check for “yes”)

German Measles  Measles  Mumps  Scarlet Fever  Chicken Pox   
 Diabetes  Pneumonia  Other: \_\_\_\_\_

#### Immunization History

Mo./Yr.

#### Allergy History

Y N

#### Drug Reaction

Y N

Small Pox Vaccine \_\_\_\_\_  
 Diphtheria \_\_\_\_\_  
 Tetanus Toxoid \_\_\_\_\_  
 Polio Vaccine \_\_\_\_\_  
 Tuberculin Test \_\_\_\_\_  
 Measles \_\_\_\_\_

Hay Fever    
 Asthma    
 Eczema    
 Hives    
 Insect Stings

Penicillin    
 Sulpha    
 Antibiotic    
 Type: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If medication to be taken during camp, please indicate name of drug and dosage:

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Please list any pertinent medical information we should have regarding past injuries, past medical history, or suggested physical limitations relating directly to the participant’s ability to participate in the camp for six or more hours per day:

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I certify the above-named individual is able to participate fully in the above-named activity, based on physical examination within 12 months prior to said camp date.

\_\_\_\_\_  
 (Signature of Physician)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Address, City, State, Zip)