

# METROCK STATION

320 Sunderland Way

Essex, VT 05452

802-878-4500

## HEALTH HISTORY AND EMERGENCY TREATMENT AUTHORIZATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Medical Insurance Policy No.: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

### In case of emergency while I'm at MetroRock Climbing Camp, please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

Alternative Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Participant Medical Information

Please explain "yes" answers to the below questions

(Does/Has) your child:

- Had a broken bone \_\_\_\_\_
- Have diabetes \_\_\_\_\_
- Have asthma \_\_\_\_\_
- Suffer from seizures \_\_\_\_\_  
Date of last: \_\_\_\_\_
- Been diagnosed with a heart murmur \_\_\_\_\_
- Suffered from joint pain/injury \_\_\_\_\_
- Been dizzy during or after exercise \_\_\_\_\_
- Had emotional difficulties for which professional help was sought \_\_\_\_\_

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- Had back problems \_\_\_\_\_
- Felt chest pain during exercise \_\_\_\_\_
- Wear glasses or contacts \_\_\_\_\_
- Ever been knocked unconscious \_\_\_\_\_
- Ever been hospitalized \_\_\_\_\_
- Ever had surgery \_\_\_\_\_

Is your child currently taking any medications (prescribed or otherwise): YES / NO

Yes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any known allergies or dietary restrictions: (food, medications, bees, insects, other): YES/ NO

Yes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any current conditions that require medication, treatment, or special restrictions or considerations while at camp:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby grant MetroRock and its agent's full authority to take whatever action they deem necessary regarding my child's health in the case of an emergency where I am unable to make a timely decision. I fully release MetroRock and its agent's from any liability in connection with those decisions. I grant permission for emergency treatment by a private physician and/or hospital or emergency health care facility staff, under the same circumstances as above, if needed. Any such action will be taken in my best interest.

Printed name of Child: \_\_\_\_\_

Printed name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**CAMPER IMMUNIZATION RECORDS ARE A GREAT SUPPLEMENT TO THE MED FORM BUT ARE NOT REQUIRED TO ATTEND CAMP.**