

Health Interview Form

Frozen Ropes Training Center
69 Kenosia Avenue
Danbury CT 06810 (203)205-0174

Location: _____
Date: _____

Date of Last Physical: _____ Date of Last Tetanus: _____

Name: _____ Age: _____ DOB: ____/____/____

Address: _____

(City) (State) (Zip Code)

Phone: _____ Work Phone: _____

Parents/Guardian Names (Please Print): _____
: _____

Family Physician: _____ Phone: _____

IN CASE OF EMERGENCY CONTACT:

If your child requires off-campus medical services, such as prescription medications or emergency evaluation, they will be transported to the closest hospital. Payment will be the responsibility of the parent or guardian. Every attempt will be made to contact you concerning any serious illness or injury. Please indicate below two different, responsible people other than yourself who can be contacted in the event you cannot be reached.

1 Name: _____

Daytime Phone: _____ Evening Phone: _____

2 Name: _____

Daytime Phone: _____ Evening Phone: _____

If your child has sustained an injury or had an illness three weeks prior to the start of camp, a physician's note is required to participate. However, Natick Frozen Ropes health care consultant has final approval. If you have any questions, please call (203-205-0174)

Health History: Answer the following comment on all positive answers on a separate sheet. Do you have or you ever had:

	Yes	No		Yes	No	In the past 24 months have you had any	Yes	No	Date of Incident
Birth Defects	___	___	Chest Pains	___	___	Orthopedic Surgery	___	___	_____
Absent or seriously Impaired organs	___	___	Palpitations	___	___	Hernia Repair	___	___	_____
Blood Disease	___	___	Rheumatic Heart	___	___	Injuries to Head (w/w o unconsciousness)	___	___	_____
Diabetes	___	___	Kidney Disease	___	___				
Neurological Conditions:			Gastrointestinal Disease	___	___				
Dizziness, Fainting	___	___	Hernia	___	___	During athletic participation problems with shoulder, neck, arm, elbow, wrist, hand, knee, or back.			
Recurring Headaches	___	___	Appendectomy	___	___				
Epilepsy	___	___	Recurring Headaches	___	___				
<u>Weakness, Paralysis</u>			Epilepsy	___	___	Have you been under a physician's care for any injury or health-related condition?	___	___	_____
Eye Problems	___	___	Contacts	___	___				
Lung Disease	___	___	Dental Appliances	___	___				
Asthma	___	___	Braces	___	___				
Heart Disease	___	___	Orthopedic Appliances	___	___				
High Blood Pressure	___	___	Heart Murmur	___	___				

Please attach a description of any "yes" answers on a separate piece of paper. Include date;

Medications

Type/Dosage _____

Medical Condition _____

Allergies

Food _____

Insect _____

Medications _____