



RFH Crew Medical Treatment Authorization

TWO SIGNATURES REQUIRED ON THIS FORM

Season: Spring 2012

Participant Name:

Home Address:

City:

Zip:

List Health Concerns

Known Allergies:

Current Medications:

LIST ONLY NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISIONS IN AN EMERGENCY SITUATION INVOLVING THE PARTICIPANT:

Mother Name:

Home/Work Phone:

Cell:

Father Name:

Home/Work Phone:

Cell:

Alternate Person with authority:

Best contact number:

PLEASE CHECK EITHER OPTION 1 OR OPTION 2 BELOW REGARDING EMERGENCY MEDICAL TREATMENT

OPTION 1 In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by the preferred doctor indicated, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my athlete to any reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery. I hereby consent for the following medical care providers to be called:

Preferred Physician and Phone:

Preferred Dentist and Phone:

OPTION 2 I do not give my consent for emergency medical treatment of the Participant. In the event of illness or injury, take the following action:

Parent/Guardian Signature _____

Date:

INSURANCE VERIFICATION - REQUIRED

Listed below is the insurance company and policy number of the contract we have in force which will pay the medical or surgical expenses that result from any injury, major or minor, that the above named participant may receive as a result of practicing or performing in rowing or all other activities related to rowing with Rumson Fair Haven Rowing Foundation, Inc. (RFH Crew). This insurance will also cover the participant while traveling to or from practice sessions or scheduled events. We, the parents of the participant, agree to release RFH Crew, its officers, coaches, volunteers, and participants or any other part thereof, from any obligations as pertains to financial responsibility in these matters for the rowing season listed above.

Insurance Company:

Policy Number:

Parent/Guardian Signature _____

Date:

RFH Crew
ATHLETE MEDICAL HISTORY QUESTIONNAIRE

Instructions: This form must be completed by a parent/guardian and turned in on the first day of practice.

Athlete Name (please print) _____

- | <u>YES</u> | <u>NO</u> | |
|------------|-----------|---|
| 1. [] | [] | Are you currently under a doctor's care? If so, who and why? |
| 2. [] | [] | Do you take any medications daily or routinely? Please list below. |
| 3. [] | [] | Allergic to any medications (aspirin, penicillin, etc)? Please list below. |
| 4. [] | [] | Allergic to any food or insect? |
| 5. [] | [] | Any chronic or recurrent illnesses (diabetes, asthma, ulcer, bronchitis, sickle cell anemia)? |
| 6. [] | [] | Any hospitalizations? |
| 7. [] | [] | Any illnesses requiring bed rest of one week or longer? |
| 8. [] | [] | Any surgery? |
| 9. [] | [] | Any surgery advised and not taken? |
| 10. [] | [] | Ever had any symptoms of heart problems? |
| 11. [] | [] | Chest pains? |
| 12. [] | [] | High blood pressure? |
| 13. [] | [] | Close relative under 40 to die of heart disease? |
| 14. [] | [] | Any dizziness, fainting, convulsions, or frequent headaches? |
| 15. [] | [] | Ever been "knocked out" or had a concussion? |
| 16. [] | [] | Wear eyeglasses or contact lenses? |
| 17. [] | [] | Any serious eye injuries? |
| 18. [] | [] | Wear any dental appliance(braces, retainer, bridge, plates)? |
| 19. [] | [] | Ever suffered heat exhaustion or heat stroke? |
| 20. [] | [] | Ever had mononucleosis? If so, month/year? |
| 21. [] | [] | Any history of enlarged spleen or liver? |
| 22. [] | [] | Any organ missing other than tonsils (appendix, eye, kidney, spleen, etc)? |
| 23. [] | [] | Any history of collapsed lung or tuberculosis? |
| 24. [] | [] | Any knee injury? |
| 25. [] | [] | Any ankle injury? |
| 26. [] | [] | Any neck injury? |
| 27. [] | [] | Any other joint sprains or dislocations (shoulder, wrist, finger)? |
| 28. [] | [] | Any broken bones (fractures)? |
| 29. [] | [] | Any communicable diseases? |

Describe any "YES" answers in detail below. Enter question number before each comment.

___ Check here if using the back of sheet.

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18

Date of Signature: