Rock Running Camp

Athlete History Form

Name _____ Date of Birth _____

Parents Name _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell _____

Email _____

ANY MEDICAL CONDITION THAT WE SHOULD BE AWARE OF: _____

Inhaler or Epi Pen? _____

Food Allergies: _____

Environmental Allergies: _____

Medication Allergies: _____

Dietary restrictions: _____

PARENTAL CONSENT:

I give permission for my child to receive necessary emergency medical treatment should the need arise. The form will be used to provide health history information to medical staff in order to treat. I will be contacted as soon as possible to provide any additional information.

PARENT NAME: _____

SIGNATURE: _____

DATE: _____

EMERGENCY CONTACT INFORMATION OTHER THAN PARENT:

Name: _____

Relationship: _____

Cell Phone: _____

Name: _____

Relationship: _____

Cell Phone: _____