MetroRock Staff Only:
Week(s):_____
Indoor/Outdoor

METROROCK NORTH

40 Parker St.
Newburyport, MA 01950
978.499.7625

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_____
  _____
- ☐ 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 REQUIRED TO ATTEND CAMP.