

**THE MOUNTAIN WORKSHOP**  
 A division of Hawke Mountain Ventures, LLC  
 9 Brookside Place  
 West Redding, CT 06896  
 (203) 544-0555 Fax (203) 544-0333  
 www.mountainworkshop.com



**HEALTH EXAM/RECORD FOR PARTICIPANTS**

**IMPORTANT:** Physical Exams and Immunization Records are valid for 3 years from the date of last exam. This completed form is required for participation in a Mountain Workshop program. **You may substitute another health form that includes the same information and is signed by a physician.**

**This Section is to be Completed by Parents**

First Program Name, Date and Location \_\_\_\_\_  
 Second Program Name, Date and Location \_\_\_\_\_

PARTICIPANT'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**This Section is to be Completed by Medical Care Provider**

Date of Exam \_\_\_ / \_\_\_ / \_\_\_

\_\_\_\_\_ May participate in all camp activities  
 \_\_\_\_\_ May participate except for: \_\_\_\_\_

Identify any known **medical or emotional illness or disorder** that would currently pose a risk to others or which would currently affect the individual's functional ability to participate safely in this program, or any **medical information pertinent to routine care and emergencies** (use back of sheet as needed):

Is this individual taking prescription or over the counter medications(s)?  YES  NO If yes, indicate names of medication(s) \_\_\_\_\_

Does the individual have allergies:  Yes  No Explain: \_\_\_\_\_

Is the individual on a special diet?  Yes  No Explain: \_\_\_\_\_

Does the individual have special needs?  Yes  No Explain: \_\_\_\_\_

This camper is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and the National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_  
 Medical care provider's address: \_\_\_\_\_  
 Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
 Signature of Physician, PA, APRN or RN

\_\_\_\_\_  
 Date Form Signed

\_\_\_\_\_  
 Telephone Number