NO STAPLES!

NEPXC Registration Forms

Email completed paperwork ***and*** check **payable to** "**Tim Longacre**" (high resolution photo/scan of BOTH sides) to: **tim@nepxc.com**

GENERAL INFORMATION

Runner Name:____________________ Date of Birth:__________ Gender:__________

Mailing Address:____________________ Town:______________ State:____ Zip:______

Home Phone:____________ Runner Cell Phone:____________ Parent Cell Phone:____________

Runner E-mail:____________ Parent E-mail:______________ Coach Name:______________

School:________________________ Grad. Year:_____ Coach Email:______________

Circle NEPXC camps attended: 2017 2016 2015 2014 2013 How did you hear about NEPXC?________________

Best Times: Mile:____ 5k:____ Longest Run Ever:_____ Weekly mileage for the 3 weeks preceding camp:______

(PLEASE CHECK)

Session 1: 8/5-9 Resident___ Day___ Roommate preference______________

My coach gives me a summer training program: Yes No (PLEASE CIRCLE)

T-shirt Size (PLEASE CIRCLE) S M L XL

If you run outdoor track, when does your racing season end?________________

Which instruments do you play?________________

	(PLEASE CIRCLE)		
Prescription medications needed at camp?	Yes*	No	* IF "YES," PAGE 3 MUST BE COMPLETED.
Is your child allergic to any medication?	Yes	No	Please specify:________________
Is your child allergic to bee stings?	Yes	No	Any other allergies:________________
Full participation in camp activities?	Yes	No	If not, please specify:________________

EMERGENCY CONTACTS:

#1 Name:______________ Relation:______ Phone 1: (   )________ Phone 2: (   )________

#2 Name:______________ Relation:______ Phone 1: (   )________ Phone 2: (   )________

Insurance Company:____________________ Group Policy Number:____________________

IF YOU WILL BE TRAVELING WHILE YOUR CHILD IS ATTENDING CAMP, PLEASE COMPLETE:

Travel Location:____________________________________Travel Ph.: (   )________

EMERGENCY CARE AUTHORIZATION

The following permission is required. Every effort will be made to contact parents in the event of serious illness, injuries, operations, or treatments. Medical attention will be provided at the Franklin County Medical Center in Greenfield, Massachusetts.

I hereby grant permission for treatment, including hospitalization of, anesthesia for, and/or surgery on my son or daughter in the event of a medical emergency.

____

Signature of Parent or Guardian

Please enroll the undersigned. I understand that neither Tim Longacre nor anyone associated with New England Prep Cross Country Camp will assume responsibility for accidents and medical or dental expenses incurred by the camper as a result of participation in this program. The camper is in good health and able to participate in the physical activity of a vigorous program. I understand the camp rules. I also understand that, if sent home for rule violations, I will not receive a refund. I agree that any damage to school or camp property will be at the participant's expense. Finally, I assign to Tim Longacre, his representatives, successors and assigns all rights to reproduce for the purpose of illustration, advertising or publication in any manner, any photographs he has taken of me.

______________________________ ______________________________

Signature of Parent or Guardian   Signature of Runner

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PHYSICAL EXAM, HEALTH HISTORY, AND IMMUNIZATION RECORD

The Commonwealth of Massachusetts Law requires that, prior to attendance, all children attending Sports Camp provide documentation for each of the three sections below. You must complete all the sections on this page **OR** append equally qualifying documentation for any section(s).

PLEASE NOTE: If the runner brings **ANY prescription medicine** from home, written authorization must be submitted by parent or guardian to administer the medicine via Page 3. **ALL PRESCRIPTION MEDICINE MUST BE HELD BY CAMP.**

Name:	Date of most recent physical examination must be within 24 months camp ending date.	DOB:	Gender (M/F)

#1—Health History

Note all past medical history on the list below along with the dates of occurrence (Month/Year)

Disease	Date
Anemia	
Asthma/Hay Fever	
Chicken Pox	
Concussion	
Diabetes	
Ear Infection	
Eczema	
Epilepsy	
Fainting	
German Measles	
Heart Disease	
Hepatitis	
Hernia	
Kidney Disease	
Measles	
Migraine	
Mononucleosis	
Mumps	
Pneumonia	
Rheumatic Fever	
Scarlet Fever	
Sinusitis	
Stomach Disorders	
Tonsillitis	
Tuberculosis	
Venereal Disease	
Whooping Cough	

#2—Certificate of Immunization

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus Influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-HIB, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History Box

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

#3—Proof of Physical Screening

Height	Weight	B/P	Pulse	HCT/HGB	Urinalysis	Gross Dental

o **I certify that this immunization information was transferred from the above-named individual's medical records. I also certify that, based on this comprehensive health history and most recent physical examination, this runner may participate in NEPXC activities without restriction.**

o **I certify that this immunization information was transferred from the above-named individual's medical records. I also certify that, based on this comprehensive health history and most recent physical examination, this runner may participate in NEPXC activities with the following restriction/adaptation:**

Physician's Signature:	Name and Phone Number (Please type or print)	Date

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AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICINE TO RUNNER

Please Note: This form must be completed if prescription medication will be brought to camp. ALL PRESCRIPTION MEDICINE EXCEPT INHALERS WILL BE HELD BY CAMP HEALTH CARE SUPERVISOR.

Diagnosis (at parents discretion): ______________________________

Name of Licensed Prescriber: ______________________________

Business Ph.: ______________________ Emergency Ph.: ______________________

Name of Medicine: ______________________ Exp. Date: ______________

Dose given at camp: ____________ Route of Administration: ____________ Frequency: ____________

Date Ordered: ____________ Duration of Order: ____________ Quantity Received: ____________

Special Storage Requirements: ______________________________

Specific Directions (e.g., on empty stomach/with water): ______________________________

Specific Precautions: ______________________________

Possible Side Effects/Adverse Reactions: ______________________________

Other medications (at parents discretion): ______________________________

Location where medicine administration will occur: Northfield Mount Hermon School, Mt. Hermon, MA

I hereby authorize New England Prep Cross Country Camp to administer, to my child, ______________ the medication(s) listed above.

105 CMR 430.160(A)

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)

Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications, if the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration or medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, there is written permission from the parent/guardian and the health care consultant approves in writing the administration of the medication.*

105 CMR 430.160(D)

When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: ______________________________ Date: ______________