



NEPXC Registration Forms
Before mailing, fax or e-mail completed paperwork and check to:
(206) 600-5022 / tim@nepxc.com

GENERAL INFORMATION

Runner Name: Date of Birth: Gender:
Address: Town: State: Zip:
Runner E-mail: Parent E-mail:
Home phone: Cell/Text Phone: Fax:
School: Grad. Year: Coach's Name:
Circle NEPXC camps attended: 2009 2008 2007 2006 2005 How did you hear about NEPXC?
Best Times: Mile: 5k: Weekly mileage for the 3 weeks preceding camp:

(PLEASE CHECK)

Session 1: 8/1-5 Resident Day Roommate preference T-shirt Size (PLEASE CIRCLE)

If a second session is offered from 8/6-10, will you sign up for both? Yes No S M L XL

(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: Home Ph.: Work Ph.:
#2 Name: Relation: Home Ph.: Work Ph.:
#3 Name: Relation: Home Ph.: Work Ph.:
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 MAKE CHECKS PAYABLE TO TIM LONGACRE. AFTER FAXING OR EMAILING, SEND COMPLETED APPLICATION AND PAPERWORK TO:
Tim Longacre, NEPXC, 10 Main Street, Cheshire, CT 06410

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

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 medication via Page 3. **ALL PRESCRIPTION MEDICATIONS 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		#2—Certificate of Immunization							
Note all past medical history on the list below along with the dates of occurrence (Month/Year)		If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)							
Disease	Date	Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type		
Anemia		Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		Haemophilus Influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1			
Asthma/Hay Fever			2			2			
Chicken Pox			3			3			
Concussion		Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-HIB, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	4			
Diabetes			2			1			
Ear Infection			3		2				
Eczema			4		Varicella (Var)	1			
Epilepsy			5		2				
Fainting			6		Hepatitis A (HepA)	1			
German Measles			7		2				
Heart Disease		Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1			
Hepatitis			2			2			
Hernia			3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1			
Kidney Disease			4			2			
Measles		Pneumococcal (PCV7)	1		Other:	3			
Migraine			2						
Mononucleosis			3						
Mumps			4						
Pneumonia									
Rheumatic Fever		Serologic Proof of Immunity		Check One		Chickenpox History			
Scarlet Fever						<input type="checkbox"/> 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			
Sinusitis		Test (if done)	Date of Test	Positive	Negative				
Stomach Disorders		Measles	/ /						
Tonsillitis		Mumps	/ /						
Tuberculosis		Rubella	/ /						
Venereal Disease		Varicella*	/ /						
Whooping Cough		Hepatitis B	/ /						
* Must also check Chickenpox History Box									

#3—Proof of Physical Screening						
Height	Weight	B/P	Pulse	HCT/HGB	Urinalysis	Gross Dental

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.

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

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION TO RUNNER

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

Diagnosis (at parents discretion): _____

Name of Licensed Prescriber: _____

Business Ph.: _____ Emergency Ph.: _____

Name of Medication: _____ 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 medication administration will occur: Northfield Mount Hermon School, Northfield, 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: _____