	Westfield Competitive Rowing, Inc.
	Health & Medical Record

X_____ _____
(Print: Athlete's Last Name, First Name) Date

In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, please complete the Westfield Competitive Rowing, Inc. (WCRI) Health & Medical Record.

NOTE: WCRI will always protect the privacy of athletes by protecting their medical information. The information contained herein may be shared with a licensed health-care practitioner elected by the Head Coach or Coach on Duty (CoD) to secure proper treatment as outlined in the WCRI Permissions and Waivers form.

Section 1: General Information

Athlete Name: _____ Date of Birth _____

Address:_____ Age _____ Male ☐ Female ☐

City _____ State_____ Zip _____

Home Phone:_____

Athlete Cell Phone: _____ Athlete e-Mail: _____

Parent 1 Name:_____Parent 2 Name:_____

Parent 1 Cell Phone: _____ Parent 2 Cell Phone: _____

Parent 1 Work Phone:_____ Parent 2 Work Phone:_____

Parent 1 E-Mail:_____ Parent E-Mail: _____

Insurance Carrier: _____ Policy No.: _____

Attach a photocopy of both sides of insurance card. ☐Family does not have medical insurance.

Family Doctor: _____Phone (____) _____ - _____

Address: _____City/State: _____

In case of emergency, every effort will be made to contact you, the parent or guardian. In the event you cannot be reached, the licensed health-care practitioner elected by the Head Coach or Coach on Duty (CoD) will secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for your child.

Alternative notification in case of emergency:

Name: _____

Relationship to Athlete: _____

Home phone: _____

Cell phone: _____

Work Phone:_____

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*X*_____ _____

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Section 2: Medical History: Please list any health conditions for which your child is being treated or monitored. Be sure to include restrictions or special care that should be observed.

Have you ever had, or do you currently have:	Yes	No
a. Restrictions for a health related problem?	☐	☐
b. A chronic or ongoing illness (such as diabetes or asthma)?	☐	☐
a. An inhaler or other prescription medicine to control asthma?	☐	☐
c. Any anemias, sickle cell disease or blood/clotting disorders?	☐	☐
d. Difficulty breathing during exercise?	☐	☐
e. Heat related problems (dehydration, dizziness, fatigue, headache)?	☐	☐
f. Other health condition	☐	☐

Explain all "Yes" answers here:

_____

_____

Weight*: _____ **lbs** **Height:** _____ **ft.** _____ **inch.**

***Male athletes 150 lbs or less and female athletes 130 lbs and less who wish to row lightweight category must provide a doctor note stating that the athlete may safely compete at the specified weight.

Immunizations: Please fill in date of last inoculation.

Tetanus Toxoid ___/___

Section 3: Allergies

Allergies or Reactions to:

	Yes	No	Explain
Medications	☐	☐	_____
Food	☐	☐	_____
Insect Bite	☐	☐	_____
Other	☐	☐	_____

Section 4: Medications

MEDICATIONS: List all medications currently used. Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

NOTE: Athletes must bring medications in the appropriate containers, and make sure that they are not expired, including **inhalers** and **EpiPens**. You should not stop taking any maintenance medication.

Medication _____ Medication _____

Reason _____ Reason _____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Athlete [Signature] _____ Date: _____

Parent/Guardian [Print] _____ Date: _____

Parent/Guardian [Signature] _____