

**Rose's Gymnastics Training Center  
Medical History for Gymnastics Day Camp**

**Child's full name** \_\_\_\_\_

**Emergency numbers:**

Name \_\_\_\_\_

Phone Number(s) \_\_\_\_\_ Cell #: \_\_\_\_\_

Relationship to child \_\_\_\_\_

Health/Accident Insurance Company \_\_\_\_\_

**RGTC Gymnastics Day Camps are designed to provide a variety of physical activity during the week. In order to give your child the best care possible, please answer the following questions. Speak with a camp staff member with any concerns or information that would help your child enjoy their camp experience with us.**

**Has the child been subject to any of the following? (Check if yes)**

Allergy to any medication, plant, animal or insect toxin \_\_\_\_\_

Asthma \_\_\_\_\_

Convulsions \_\_\_\_\_

Dental problems \_\_\_\_\_

Diabetes \_\_\_\_\_

Earaches \_\_\_\_\_ Swimmers ear \_\_\_\_\_

Fainting spells \_\_\_\_\_

Fears of any kind \_\_\_\_\_

Food allergies \_\_\_\_\_

Heart trouble \_\_\_\_\_

Motor skills \_\_\_\_\_

Nosebleeds \_\_\_\_\_

Speech \_\_\_\_\_

Vision \_\_\_\_\_ glasses \_\_\_ contacts \_\_\_

Any other condition that may require special care of any kind? \_\_\_\_\_

Any condition now requiring regular medication? \_\_\_\_\_

Name of medication \_\_\_\_\_

If medication needs to be given during camp please see the camp director for the release form.

Any restriction of activity for medical reasons? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Immunizations up to date yes \_\_\_ no \_\_\_

If no please explain \_\_\_\_\_