



Thank you for your interest in The Running School Camp. You will gain running strength and the necessary skills to keep you ahead. Please take the time to make sure you have all the necessary items listed below when submitting your application.

## **APPLICATION CHECKLIST**

Please send these items first

- Registration Form
- Parent Consent & Emergency Contact Information Form
- Deposit

Please send these items by August 1<sup>st</sup> 2008

- Camper Physical Exam/Medical Form
- Copy of Medical Insurance Card
- Final Payment



## 2008 REGISTRATION FORM

I wish to enroll in The Running School Cross Country Camp held August 21st -27th, 2008.

A \$ 300 non-refundable deposit must accompany this registration.

**All registered campers receive a free pair of Reebok™ Sneakers.**

Please make a check or money order payable to

“The Running School, Inc”

and mail to

109 Summit Street Oyster Bay, NY 11771

Total Summer Mileage Anticipated \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_\_\_

Grade as of 9/07 \_\_\_\_\_ Sex \_\_\_\_\_ Shirt Size \_\_\_\_\_ Shoe Size \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

School \_\_\_\_\_ Coach \_\_\_\_\_

Circle events and list best times for

800m \_\_\_\_\_

1500m \_\_\_\_\_

1600m \_\_\_\_\_

3000m \_\_\_\_\_

3200m \_\_\_\_\_

Please list best cross-country

Course \_\_\_\_\_

Time \_\_\_\_\_

Distance \_\_\_\_\_

Each camp season, we update our website with professional pictures and video of our wonderful campers in action. A gallery will be posted for all campers and coaches to view and share.

I do not give The Running School permission to use my picture on the website or promotional materials.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

The Running School Camp: \$550

Optional

The Varsity Club: \$100

(includes The Running School Sweatshirt, technical shirt, DVD of camp, and private pizza party with guest speakers)

Bus Transportation:  1 Way To Camp \$65  1 Way From Camp \$65  Round Trip \$100

Total: \$ \_\_\_\_\_

# 2008 Parent Consent & Emergency Information

**PARENT SECTION:** Completed and signed by parent/guardian

Please PRINT

Name of Camper \_\_\_\_\_ Social Security # \_\_\_\_\_

ADDRESS:

\_\_\_\_\_

No & Street	City	State	Zip
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Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

AGE: \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Work Mother/Father (\_\_\_\_) \_\_\_\_\_

Physician Name: \_\_\_\_\_

Office Telephone (\_\_\_\_) \_\_\_\_\_

If the child brings **prescription medicine** from home, the parent or guardian must submit written authorization for the administering of the medications. Prescription medications for campers will be stored and the infirmary staff will observe self-administration of the medicines.

This is to certify that the above camper has my permission to participate in all regular camp and swimming activities. I am aware of the physical nature and stresses required by the activities of this camp. I further certify that a physician has examined my child or ward and I have been advised that my child or ward is approved to participate in this camp's activities. In the event of an emergency, I give permission to the infirmary staff on duty to hospitalize, secure proper treatment for, and to order x-rays, medication including intravenous medication and/or surgery for this camper. The parent/guardian accepts responsibility of payment for medical bills.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT/GUARDIAN NAME, Please Print:** \_\_\_\_\_

**ADDITIONAL EMERGENCY CONTACTS- Please Print**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION (PLEASE ATTACH COPY OF INSURANCE CARD)**

**COMPANY NAME** \_\_\_\_\_

**POLICY #** \_\_\_\_\_ **TELEPHONE (\_\_\_\_)** \_\_\_\_\_

# 2008 Camper Physical Exam

## Please return this form by August 1.

The Running School **requires all students** attending camp to have a **Physical Exam** within **3 months of attending**. Signed medical release, health history, immunization record, and insurance information must be on file for campers to participate. **No forms. No running until forms on file.** (The camp must comply with regulations of the NY Health Department and be licensed by the local board of health).

**CAMPER NAME** \_\_\_\_\_  
LAST NAME
FIRST NAME
SCHOOL

PHYSICIAN SECTION: PLEASE HAVE MEDICAL EXAMINER COMPLETE THIS SECTION

**IMMUNIZATION RECORD** – Please give **MONTH/YEAR** of last occurrence of clinical disease (or enclose copy of immunization record)

DTP: _____ OR	MMR _____ OR	Polio _____	HIB _____
Diphtheria _____	Measles _____	Influenza _____	
Pertussis _____	Mumps _____	Chicken Pox _____	
Tetanus _____	Rubella _____	Hepatitis B _____	

**MEDICAL HEALTH HISTORY** – Please mark **PAST/CURRENT** medical issues with **DATES** of OCCURANCE

	Yes	No		Yes	No		Yes	No
Anemia			Asthma, Hay Fever			Chicken Pox		
Concussion			Diabetes			Ear Infection		
Eczema			Epilepsy			Contacts/Glasses		
Fainting			German Measles			Heart Disease		
Hepatitis			Hernia			Kidney Disease		
Measles			Migraine			Mononucleosis		
Mumps			Pneumonia			Rheumatic Fever		
Scarlet Fever			Sinusitis			Stomach Disorders		
Tonsillitis			Tuberculosis					

**OPERATIONS:** \_\_\_\_\_

**RECENT ILLNESS (Previous 3 months)** \_\_\_\_\_

**INJURIES:** \_\_\_\_\_

State **ALL MEDICATIONS** person is currently taking \_\_\_\_\_

Medication which may be needed at camp? \_\_\_Y \_\_\_N please Specify: \_\_\_\_\_

Prescription Medication to be dispensed \_\_\_\_\_

With signed consent of the parent and physician, prescription medication for the camper will be stored and the infirmary staff will observe self-administration of the medicines.

Is the child permitted over-the-counter drugs \_\_\_Y \_\_\_N Please specify: \_\_\_\_\_

List **ALLERGIES** to drugs and/or foods: \_\_\_\_\_

Is the child allergic to any medication? \_\_\_Y \_\_\_N Specify: \_\_\_\_\_

Is the child allergic to bee stings? \_\_\_Y \_\_\_N Specify: \_\_\_\_\_

Other allergies: \_\_\_Y \_\_\_N Specify: \_\_\_\_\_

**MEDICAL RELEASE:** I have examined this child and he / she is physically able to participate in all of the Running Schools activities and in addition, I authorize the Running School to store and observe the self-administration of above listed medications.

**Signature** of Medical Provider \_\_\_\_\_ **Date** \_\_\_\_\_