



500 Holden Way, Carbondale, Colorado 81623
tel: 970-963-2562 fax: 844-254-3808

To Parent(s)/Guardian(s): Complete this section and give this form and a copy of your completed STUDENT MEDICAL HISTORY FORM to your child's health-care provider for review.

Student Name: _____

First Middle Last

Male Female Birth Date _____ Age on arrival at CRMS _____
Month/Day/Year

Student home address: _____

City State Zip Code

Custodial parent(s)/guardian(s) phone: (_____) (_____) _____

Parent(s)/guardian(s) STOP HERE. Remainder of form to be completed by medical personnel.

Medical Personnel: Please review STUDENT MEDICAL HISTORY FORM and complete all remaining sections of this form. Attach additional information if needed. CRMS welcomes students of all fitness levels and does not assume any previous outdoor experience prior to coming to school. Students will be involved in various activities including hiking and backpacking in mountainous terrain (at high altitude). Additionally, students can elect to participate in river and mountain sports such as skiing, snowboarding, mountain biking, kayaking, canoeing, and climbing. As you complete this important medical history form, please consider the scope, demands and environmental factors of our sport, outdoor and service programs.

Physical exam done today: Yes No (If "No," date of last physical mm/dd/yy: _____)

NOTE: All students must have a physical completed within 12 months of their start date at school.

Weight: _____ lbs Height: _____ft____in Blood Pressure _____/_____

Allergies: No Known Allergies

To foods (list):

To medications: (list):

To the environment (insect stings, hay fever, etc.– list): Other allergies: (list):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions:(describe below)

The student is undergoing treatment at this time for the following conditions: (describe below) None.

Medication: No daily medications. Will take the following prescribed medication(s) while at school: (name, dose, frequency–describe below)

Other treatments/therapies to be continued at school: (describe below) None needed.

Do you feel that the student will require limitations or restrictions to activity (as described above) while at school? No Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the STUDENT MEDICAL HISTORY FORM, and have discussed the school program with parent(s)/guardian(s). It is my opinion that the student is physically and emotionally fit to participate in the Active Program at Colorado Rocky Mountain School (except as noted above.)"

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip Code

Telephone: (_____) _____ Date: _____