**MAKE RUNNING FUN / CAMP SCATICO**

**HEALTH HISTORY & PHYSICAL FORM**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please fill in the following information and have it reviewed by your doctor* ***within one year of the start of camp****.* ***The camp health personnel must be informed of any changes to this form upon arrival at camp.***

*Place a check in the appropriate column that corresponds to each item below. If “yes” provide details and dates.*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  |  | **Yes** | **No** |  |  | **Yes** | **No** |
| Dental Problems |  |  |  | Insomnia |  |  |  | Frequent Diarrhea/Constipation |  |  |
| Convulsive Disorders |  |  |  | Skin Rashes |  |  |  | Shortness of Breath |  |  |
| Diabetes |  |  |  | Seasonal Allergies |  |  |  | Recent Weight Loss/Gain |  |  |
| Emotional Problems |  |  |  | Frequent UTIs |  |  |  | Smoke Cigarettes |  |  |
| Headaches |  |  |  | Anemia |  |  |  | Fifth’s Disease |  |  |
| Asthma |  |  |  | Heart Disease |  |  |  | Chicken Pox |  |  |
| Bleeding Problems |  |  |  | Eating Disorder |  |  |  | Measles |  |  |
| Depression/Anxiety |  |  |  | Hepatitis A, B, C |  |  |  | Mumps |  |  |
| Eneuresis |  |  |  | Live/Scabies |  |  |  | Rubella |  |  |

If answered “yes”, please provide specific details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other history of medical conditions or surgical procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES (List all known)**  Is participant receiving regular allergy shots? Yes \_\_\_\_\_\_No \_\_\_\_\_\_

**Medication allergies (list)** Describe ***reaction*** and ***management of the reaction***.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Food allergies (list)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other allergies** (list: include insect stings, hay fever, asthma, animal dander, ect.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**New York State Health Law, Chapter 2164 requires that all campers/staff complete and submit the following information: CHECK ONE (1) BOX ONLY AND SIGN BELOW**

**I have (campers/staff under the age of 18: My child has):**

\_\_\_\_ had the meningococcal meningitis immunization (Menomune) within the past 10 years.

Date Received:

\_\_\_\_ read, or have explained to me, the information regarding meningococcal meningitis disease, I understand the ricks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Staff, Parent/Guardian if camper is a minor)

Health History Continued

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give **DATES** for **ALL DOSES** for the following immunizations:

**DTP #1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#3** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#4** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#5** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year Month Day Year Month Day Year Month Day Year Month Day Year

**TD (Tetanus/Diphtheria) #1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_**Haemophilus (HIB)#1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#3** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

(within 10 years) Month Day Year Month Day Year Month Day Year Month Day Year

**Polio #1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#3** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#4** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year Month Day Year Month Day Year Month Day Year

**Varivella (chicken pox) #1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year Month Day Year

**MMR #1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **or**  **Measles #1**\_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year Month Day Year Month Day Year Month Day Year

**or Mumps #1**\_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year

**or Rubella #1**\_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year

**Hepatitis B #1** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#2** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **#3** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Month Day Year Month Day Year Month Day Year

Camper is under the care of a physician for the following conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current treatment at the time of this report includes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment to be continued at camp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Description of any limitation or restriction on camp activities, including dietary restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Use this space to provide additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Parent/Guardian Authorization:** This health history is correct and complete as far as I know, and the camp participant has permission to engage in all camp activities except as noted. I will advise the camp of any changes to this form upon arrival at camp.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical:** This page must be fully completed, signed by a doctor and returned to be fully registered.

Note: The physical must be dated no more than a year before the last day of camp.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Exam** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ht.** \_\_\_\_\_\_\_\_\_\_**Wt.** \_\_\_\_\_\_\_\_\_\_**Pulse** \_\_\_\_\_\_\_\_\_\_\_\_\_**BP** \_\_\_\_\_\_\_\_\_\_\_\_**T** \_\_\_\_\_\_\_\_\_\_\_\_**Resp**\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last TB Mantoux Test** \_\_\_\_\_\_\_\_\_\_\_\_ **Result** \_\_\_\_\_\_\_\_\_\_**If positive, date of chest X-ray** \_\_\_\_\_\_\_\_\_\_**Result** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Heart**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Breasts** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Corrected** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Abdomen** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GYN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nose** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Lymphatics** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth & Throat** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Extremities** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neck**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Neurological** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chest** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Skin** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CBC Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Urinalysis Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTIONS:**

Please list all medications- prescriptions and over-the-counter – to be taken during camp, *even those only taken on an “at needed” basis.* A note on prescriptions: nurses can only administer prescription medications that have been packed by a licensed pharmacist that identifies the prescribing physician, name of medication, dosage, and frequency and route of administration. **Nurses cannot administer medications – prescription or over the counter – unless the physician signs below.**

Name of Medication Frequency and Dosage Reason for Taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**OVER THE COUNTER MEDICATIONS:**

Camp physicians may prescribe OTC medications such as Tylenol, Claritin, and cortisone cream. List any restrictions on non-prescription medications.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate ALL medications taken during the school year that participation will NOT be taking during the camp season:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Licensed Medical Personnel Authorization: I have reviewed this form in its entirety. The heath history and physical exam is complete and the camp participant has permission to engage in all camp activities exact as noted above.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License # \_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_** Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_**