Cooperstown All Star Village

Baseball Camp Health Examination Form

Form Must Be Completed and Mailed with Final Payment. To:
Cooperstown All Star Village
PO Box 670
Cooperstown, NY 13326

This side to be completed by parent

Name :____ **Birth Date** _____________ **Sex** ____ **Age** ___

Last First Initial

Team Name: ____ **Coach:** _________________________________

Parent/Guardian (or Spouse) ____ **Phone** **(H)**_______________

(W)_______________

Home Address____

Street & Number City State ZIP

If not available in an emergency notify:

____**Phone**________________________

Emergency Contact 1 Name **Area/ Number**

____

Street & Number **City** **State** **ZIP**

____**Phone**________________________

Emergency Contact 2 Name **Area/ Number**

____

Street & Number **City** **State** **ZIP**

Personal History : (check the condition you have had)

- ❑ Alcohol Dependency
- ❑ Allergy
- ❑ Anemia
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chicken Pox
- ❑ Hepatitis Type B
- ❑ Diabetes
- ❑ Drug Dependency
- ❑ Eczema
- ❑ Epilepsy
- ❑ German Measles
- ❑ Heart Disease
- ❑ Jaundice
- ❑ Measles
- ❑ Mumps
- ❑ Nephritis
- ❑ Otitis Media
- ❑ Pneumonia
- ❑ Psychiatric
- ❑ Psychological/Counseling
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Tonsillitis
- ❑ Haemophilus Influenza Type B

Operations, Injuries and Hospitalizations (with dates)

____

____

Present Medications or Treatments

____

____

Please List All Allergies, Including Allergies to Medications

____

____

<u>Important:</u> Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

PERSONAL HEALTH INSURANCE CO.

ADDRESS____**ID#**___________________________

***PARENT AUTHORIZATION: This health history is correct so far as I know, and the person herein described has my permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.**

PARENT SIGNATURE: ____ **DATE:** ____________________

PATIENT NAME: ____
LAST FIRST DOB

REQUIRED FOR REGISTRATION, IMMUNIZATIONS MUST PRECEDE REGISTRATION ELIGIBILITY

TETANUS DIPHTHERIA TOXOID (minimum 2 doses, booster within 10 yrs).....**DATE**_____________________
POLIO VACCINE (complete series of Oral/ Salk)...**DATE**_____________________
MUMPS VACCINE (after 1st birthday)..**DATE** _____________________
MEASLES VACCINE (after 1st birthday) (2 doses mandatory)..................................**1st** _______**2nd** _______
RUBELLA VACCINE (after 1st birthday)...**DATE** _____________________
OR MMR (Mumps, Measles, Rubella) (after 1st birthday ....**1st**_______**2nd** ________
OR: MUMPS TITER (valid only if lab report included) ....**RESULT**_______**DATE**___________
MEASLES TITER (valid only if lab report included)..**RESULT**_______**DATE**___________
RUBELLA TITER (valid only if lab report included)..**RESULT**_______**DATE**___________

MEDICAL EXAMINATION- To be filled out by licensed physician, physician's assistant, or nurse practitioner.

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

CODE: ❐ Satisfactory ❐ Not Satisfactory (explain) ❐ Not Examined
HTG.______________ **WT.**________________ **B.P.**______________

Eyes____________________________ Teeth___________________________ Posture (spine)_________________
Glasses__________________________ Heart____________________________ Skin____________________________
Ears_____________________________ Abdomen_______________________ Allergy_________________________
Nose____________________________ Hernia_________________________ Lungs__________________________
Throat___________________________ Extremities____________________

Recommendations and restrictions while in camp:

Special Diet ____
Special Medication (identify)____
Dispensing protocol____
Can this camper participate in unrestricted recreational activity? ______________________________________

If no, explain: ____
____
Other: ____
____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Telephone _______________________ Examining Physician/Physician's Asst. Nurse Practitioner _______________________

Date _______________________ Address _______________________