



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)

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

Operations, Injuries and Hospitalizations (with dates)

Present Medications or Treatments

Please List All Allergies, Including Allergies to Medications

Important: 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 birthday1st _____ 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