



PROFESSIONAL BASEBALL INSTRUCTION, INC.

***1-800-282-4638* WWW.BASEBALLCLINICS.COM**

PLAYER HEALTH FORM

Student Last Name	First	Home Phone	Birthdate	Age
Parent's Name		Business Phone - Mother		
Street	Apt. #	Business Phone - Father		
Town, State & Zip		Cell Phone - Mother		
If not available in emergency, notify:		Emergency Phone	Cell Phone - Father	
HEALTH HISTORY				
1. List record of past medical treatment; (i.e. Major illness, hospitalization, surgery)		New Jersey State Department of Health REQUIRE ALL IMMUNIZATION DATES		
		Date of Immunization		Date of last Booster
		Hepatitis		
		Diphtheria Pertussis Tetanus or		
2. List ALL Allergies:		Tetanus Diphtheria or		
		Tetanus		
		Polio		
3. Describe any health conditions requiring special considerations, or restrictions of any kind		Measles		
		Mumps		
		Rubella		
4. Indicate any medication your child is taking that camp staff should be aware of:				
5. I hereby authorize camp staff to administer the following medication (please include: original dose container; instructions; amount to be given; time to be given & days to be given):				

NOTE: Medication must be in officially labeled bottles.

Permission is granted for the camp medical trainer to administer Tylenol if necessary. YES ____ NO ____
Permission is granted for the camp to seek necessary emergency medical treatment in the event that the parent cannot be reached by telephone.

Parent Signature

Date