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)

2. List ALL Allergies:

3. Describe any health conditions requiring special considerations, or restrictions of any kind

New Jersey State Department of Health
REQUIRE ALL IMMUNIZATION DATES

	Date of Immunization	Date of last Booster
Hepatitis		
Diphtheria Pertussis Tenanus or		
Tenanus Diphtheria or		
Tetanus		
Polio		
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