YOUTH CAMP HEALTH EXAM/RECORD
For Players and Instructors/Staff
Physical Exams Are Valid For *three* years
From Date of Last Examination

_____ Player

_____ Instructor/Staff

Please Return Completed Form to Baseball World

Name _____ Date of Birth_____ Telephone _____

Guardian _____ Address _____

Emergency Contact _____ Telephone _____

Date of Arrival at Camp _____ Departure Date _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam_____

_____ May participate in all camp activities
_____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies: _____

_____

Is the individual taking prescription medication? ___ Yes ___ No
If yes, indicate prescription: _____

Does the individual have allergies? ___ Yes ___ No Explain: _____

Is the individual on a special diet? ___ Yes ___ No Explain: _____

This player/instructor/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Academy Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments:_____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST_____ Zip Code _____

_____
Signature of Physician, APRN or PA

_____
Date Form Signed

_____
Telephone Number