Cooperstown All Star Village

Baseball Camp Health Examination Form

Form Must Be Completed and Mailed by March 1st to:
Cooperstown All Star Village
PO Box 670 Cooperstown, NY 13326

This side and Insurance Information and Parental Authorization on Page 2 to be completed by parent

Player Name:_____ Birth date_____ Sex____ Age_____
Last First MI

Team Name_____ ___Coach_____

Parent/Guardian_____ Phone (H)_____

Email address_____(C)_____ (W)_____

Home address_____
Number & Street City State ZIP

If not available in an emergency notify:

_____ Phone_____
Emergency Contact 1 Name & relationship

_____
Number & Street City State ZIP

_____ Phone_____
Emergency Contact 2 Name & relationship

_____
Number & Street City State ZIP

Personal History (check all conditions you have or have had)

- ○ Alcohol Dependency
- ○ Allergy
- ○ Anemia
- ○ Asthma
- ○ Bronchitis
- ○ Chicken Pox
- ○ COVID-19
- ○ Diabetes
- ○ Drug Dependency
- ○ Eczema
- ○ Epilepsy
- ○ German Measles
- ○ Haemophilus Influenza Type B
- ○ Heart Disease
- ○ Hepatitis Type B
- ○ HIV/AIDS
- ○ Jaundice
- ○ Measles
- ○ Mumps
- ○ Nephritis
- ○ Otitis Media
- ○ Otitis Media
- ○ Pneumonia
- ○ Psychiatric/ Counseling
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Tonsillitis

Operations, Injuries and Hospitalizations (with dates)

_____

_____

Current Medications or Treatments – All Prescription medications/treatments must also be listed on the Medication Form and be signed by a physician

_____

_____

Please list ALL allergies, including allergies to medications

_____

_____

IMPORTANT: Please notify Camp Medical Personnel if this camper was exposed to or exhibited any symptoms of ANY communicable disease during the three weeks prior to camp attendance..

Player Name_____ Team _____

PERSONAL HEALTH INSURANCE

Insurers Name_____ ID#_____

Parental 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 named above.

PARENT SIGNATURE _____ DATE_____

PATIENT FULL NAME _____ Date of Birth_____

REQUIRED FOR REGISTRATION, IMMUNIZATIONS MUST PRECEDE REGISTRATION ELIGIBILITY

TETANUS DIPTHERIA TOXOID (minimum 2 doses, booster within 10 years) …… **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 is included) …… **RESULT**_____ **DATE**_____
AND MEASLES TITER (valid only if lab report is included) ……RESU**LT**_____ **DATE**_____
AND RUBELLA TITER (valid only if lab report is included) ……RESULT_____ **DATE**_____

MEDICAL EXAMINATION – To be completed by licensed physician, physician's assistant or nurse practitioner

This examination must 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: S – Satisfactory NS – Not Satisfactory NE – NOT EXAMINED

Height _____ Weight_____ Blood Pressure_____

Eyes _____ Teeth_____ Posture/Spine_____
Glasses_____ Heart_____ Skin_____
Ears_____ Abdomen_____ Allergy_____
Nose_____ Hernia_____ Lungs_____
Throat_____ Extremities_____

Recommendations and restrictions while in camp:

Special diet/Dietary restrictions_____
Special medications (identify) _____
Dispensing protocol_____
Can this camper participate in unrestricted recreational activity? _____Yes _____No
If no, please 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.

_____ _____
Examining Physician/PA/FNP Address

_____ _____
Date Telephone Number