



Personal Health & Medical History

This form is to be completed by the parent(s), legal guardian, or adult participant.

Players Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Name of Parent or Guardian: _____ Telephone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Business Address: _____ City: _____ State: _____ Zip: _____

If the person named above is not available in the event of an emergency, notify:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Name of Family Physician: _____ Telephone: _____

Personal health/accident insurance carrier: _____ Policy #: _____

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult).

Signature: _____ Date: _____

Check all items that apply, **past or present**, to the player's history. Explain "yes" answers.

GENERAL INFORMATION

| | | | | | | | | |
|-----------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| | Y | N | | Y | N | | Y | N |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> |

Explain _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

List any medications to be taken during the day: _____

List any physical or behavioral conditions that may affect or limit full participation in playing baseball: _____

IMMUNIZATIONS:

Are the player's shots up-to-date? Yes No