



# Springfield Area Baseball School

## Health Form

“According to Massachusetts General Law 105 CMR 430.000 ALL CAMPERS MUST SUBMIT, IN COMPLETION, THE HEALTH FORM BELOW”

Participant Name: (print)

\_\_\_\_\_ (Last) (First) (M)

**Section I: (To be completed by Parent or Guardian)**

Name \_\_\_\_\_

Birth date: \_\_\_\_\_ (Last) (First) (Middle)

Month/ Day/ Year

Address \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Program Name: \_\_\_\_\_

Program Dates: \_\_\_\_\_

Soc. Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father: \_\_\_\_\_

Telephone: (Day time) ( ) \_\_\_\_\_

Telephone (Evening) ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_

Guardian is: Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Day time) ( ) \_\_\_\_\_

Telephone (Evening) ( ) \_\_\_\_\_

In case of illness or emergency the name and telephone number of a person to contact (Relation to Participant)

Family Physician or HMO

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Telephone: (Day time) ( ) \_\_\_\_\_

Family Dentist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Day time) ( ) \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

If there is any reason this child should not participate in baseball camp \_\_\_\_\_ yes \_\_\_\_\_ no

If yes explain: \_\_\_\_\_

In case of medical emergency, I hereby give permission to the Health Care Supervisor to hospitalize, to secure proper treatment for, and to order injection to minor surgery for my child as named above.

1. Signature _____	Date _____
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**IV. CAMP ACTIVITIES AUTHORIZATION**

I/we the undersigned, for ourselves, our heirs, executors and administrators, waive, release and forever discharge Western New England College/Springfield College and its staff, officers, agents, employees, representatives, successors and assignees of and from all rights and claims for damages, injuries, or loss of person or property which may be sustained or occur during participation in camp activities or while at camp.

2. Signature _____	Date _____
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**Section II: Physical Examinations**

(Must be in the preceding 24 months and done by a Medical Provider)

**Medical History:** (Please note significant disorders)

Allergies \_\_\_\_\_ Heart \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
Kidney \_\_\_\_\_ Lung \_\_\_\_\_ Diabetes \_\_\_\_\_  
Varicella \_\_\_\_\_ Disabilities \_\_\_\_\_ Neurological \_\_\_\_\_  
Whooping Cough \_\_\_\_\_ Other \_\_\_\_\_  
Pertinent Medical History: \_\_\_\_\_

Child Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Summary of Significant Treatment Program Including  
Names/Dose of Medications to be used while at program:  
(Medications MUST be in a container with the original label)

**Section III: Immunizations**

Has completed primary series of tetanus/diphtheria? (Four doses) Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Series- Type of Vaccine

OVP IPV E-IPV \_\_\_/\_\_\_/\_\_\_

Laser Booster- Type of Vaccine

OVP IPV E-IPV \_\_\_/\_\_\_/\_\_\_

**IMMUNIZATION DATES**

Diphtheria/tetanus (Td)  
Must be within last ten years \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Measles #1 (Rubeola, Red Measles)  
Must be AFTER age 12 months or \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MMR #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Or  
Positive Measles Titer (Blood test) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Measles #2 (Rubeola, Red Measles)  
Must be at least 30 days AFTER first dose \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Or  
MMR #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mumps or MM#1  
Must be AFTER age 12 months \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Or  
Positive Mumps Titer (Blood test) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Rubella (German Measles) or MMR #1  
Must be AFTER age 12 months \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Or  
Positive Rubella Titer (Blood test) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Hepatitis B- Those born AFTER 1-1-92  
Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Medical exemption: The above named person does not have one or more of the required immunizations because he has medical problem (s) that precludes the \_\_\_\_\_ vaccine (s).

**Health Care Provider/ Physician:**

Signature and/ or stamp: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_