

# ANDOVER WARRIOR BASEBALL SCHOOL

## HEALTH HISTORY

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

EMERGENCY CONTACT (FAMILY): \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

SECOND EMERGENCY CONTACT: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

DENTIST'S NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

HOSPITAL PREFERENCE: \_\_\_\_\_ HEALTH INSURANCE: \_\_\_\_\_ POL.#: \_\_\_\_\_

### MEDICAL INFORMATION

ALLERGIES: Food (Please List): \_\_\_\_\_

Medication (Please List): \_\_\_\_\_

(Check)  Poison Ivy/Oak  Hay Fever  Mosquitoes  Insect Stings  Nuts  Other

Medications: \_\_\_\_\_

Any prescribed medication must be given to the Health Care Supervisor in it's original container, clearly marked with your name , date, dosage and instructions. List all current medications, dosage and instructions. \* The Parent must administer any medications, which need to be taken during baseball school.

\*\*\* What medications will be taken at Camp? \_\_\_\_\_ What medications will be taken at Home? \_\_\_\_\_

Active Health Concerns: Please Check All That Apply:

Seizures  Diabetes  Asthma  Fainting  Chicken Pox

Other

Conditions: \_\_\_\_\_

Recent Operations or Serious Injuries: \_\_\_\_\_

Date Last Seen by a Physician: \_\_\_\_\_

Are you allergic to ibuprofen (Advil) or acetaminophen (Tylenol) ? \_\_\_\_\_

### RELEASE STATEMENT

I UNDERSTAND THAT Andover Warrior Baseball School cannot be held responsible in whole or in part for any accident resulting in medical or dental expenses incurred from participation in this program. I hereby release them from and against any and all claims, cost, liabilities and injuries incurred while working this school. I agree to assume full and complete responsibility for any and all medical bills resulting from my participation. In the event of an emergency, I authorize Andover Warrior Baseball School to exercise its judgment in any necessary emergency medical treatment.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature Of Parent

Have you had **CHICKEN POX**? If YES, When? \_\_\_\_\_

Have you had the **Vaccine**? If YES, When? \_\_\_\_\_

**\*NO STUDENT WILL BE REGISTERED WITHOUT THIS COMPLETED FORM.**

**All paperwork should be completed and on file with the Baseball School by June 1<sup>st</sup>.**

**Any Questions? Contact phone 603-635-2158 or ken.maglio@comcast.net**