

Annual Andover Warriors Baseball School LLC
Health History Form
CONTACT INFORMATION

Student's Name: _____ Age: _____ DOB: _____

Full Address: _____

Parent/Guardian Name: _____ Day Phone: _____

Night Phone: _____

If Parent or Guardian unavailable, please list adult that we may call in an emergency:

Name: _____ Phone #: _____

MEDICAL INFORMATION

Insurance Company: _____ Policy #: _____

Student's Physician: _____ Phone #: _____

Student's Dentist: _____ Phone #: _____

Date of Last Physical: _____

Does your son/daughter have any allergies? Yes _____ No _____

If Yes, please explain: _____

IMMUNIZATION RECORD

Health Departments are very strict and require us to have on site for every student a current immunization record. **Please attach a current immunization record from your physician** or have a physician complete the chart on the second page of this form.

RELEASE STATEMENT

By enrolling my child, I ensure that he/she is physically and mentally able to participate in all the program activities. I understand that at Andover Warrior Baseball School LLC cannot be held responsible in whole or in any part for any accident resulting in medical or dental expenses incurred from participation in the program. I hereby release them from and against any and all claims, cost, liabilities and injuries incurred while at this baseball school. I agree to assume full and complete responsibility for any and all medical bills resulting from player participation. I understand every effort will be made to contact parents or guardians of participants in an emergency. In the event that I cannot be reached, I authorize Andover Warrior Baseball School LLC to exercise its judgment in the treatment of my son/daughter by a medical authority. I have completed this health history in full and attached a current immunization record.

Signature (Parent or Guardian): _____ Date: _____

NO STUDENT WILL BE REGISTERED WITHOUT THIS COMPLETED FORM

All forms should be on file with the Baseball School by **June 1st**.

Any questions? Contact phone # (978)273-2069 eMail: KMaglio@APS1.net

Annual Andover Warriors Baseball School LLC

Physical Immunization Form*

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

PREVIOUS DISEASES AND OPERATIONS

PHYSICAL EXAMINATION

Date of Exam _____
 Height _____ Weight _____
 Nutrition _____
 General Body _____
 Type _____
 Posture (scoliosis or lordosis) _____
 Skin _____
 Eyes _____
 Ears _____
 Nose _____
 Mouth _____
 Teeth _____
 Pharynx _____
 Thyroid _____
 Lymph Glands _____
 Lungs _____
 Heart _____
 Blood Pressure _____
 Pulse rate at rest _____
 After exercise _____
 2 minutes after exercise _____
 Abdomen _____
 Hernia? _____
 Genitalia _____
 Skeleton _____
 Feet _____
 Reflexes _____

Is the child currently taking any medication?
 Yes _____ No _____
 If yes, please list _____

Comments / Recommendations:

Signature of Physician: _____

Physician's Name: _____ Date: _____

IMMUNIZATIONS

Immunizations are required by law, unless exempted for religious reasons.

D.P.T. #1 _____	Polio #1 _____
D.T. #2 _____	IPV #2 _____
DTaP #3 _____	OPV #3 _____
#4 _____	#4 _____
#5 _____	#5 _____

T.D. _____
 Measles Vaccine _____
 Mumps Vaccine _____
 Rubella Vaccine _____
 M.M.R. #1 _____ #2 _____
 Hepatitis B #1 _____ #2 _____ #3 _____
 Hib #1 _____ #2 _____ #3 _____
 Varicella (Vaccine) _____
 Chicken Pox (Disease) _____

TESTS

Lead Test _____	Results _____
Tuberculin _____	Results _____
Urinalysis _____	Date _____

Is the child capable of carrying a full program of school work, including gymnastics & athletics?
 Yes? _____ No? _____

Must the school program be modified to meet the needs of this child?
 Yes? _____ No? _____

By restriction of use of stairs?
 Yes? _____ No? _____

By special seating accommodations?
 Yes? _____ No? _____

Other (please specify)?

**Physician issued Physical and Immunization form for child enrolling in Baseball School acceptable as replacement to this form.*