

STAYNER MINOR BASEBALL ASSOCIATION

HEALTH STATUS FORM

NAME OF PARTICIPANT: _____ AGE: _____

GENDER: (PLEASE CIRCLE) MALE FEMALE

DATE OF BIRTH: _____ PHONE NUMBER: (____) _____
(Day / Month / Year)

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: (____) _____

FAMILY DOCTOR: _____ PHONE NUMBER: (____) _____

FAMILY DENTIST: _____ PHONE NUMBER: (____) _____

PERSONAL HEALTH CARD NUMBER: _____

DO ANY OF THE FOLLOWING CONDITIONS APPLY TO THIS PARTICIPANT?

ALLERGIES: (Please Circle) DRUG FOOD PLANT INSECT ENVIRONMENTAL OTHER

DATE OF LAST COMPLETE PHYSICAL EXAMINATION: _____

*BEFORE PLAYER PARTICIPATES IN A BASEBALL PROGRAM, ANY MEDICAL CONDITION OR INJURY PROBLEM SHOULD BE CHECKED BY THAT INDIVIDUAL'S FAMILY PHYSICIAN.

PLEASE CIRCLE THE APPROPRIATE RESPONSE AND PROVIDE DETAILS BELOW IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS.

YES	NO	PREVIOUS HISTORY OF CONCUSSIONS
YES	NO	FAINING EPISODES DURING EXERCISE
YES	NO	EPILEPTIC
YES	NO	WEARS GLASSES
YES	NO	ARE LENSES SHATTERPROOF
YES	NO	WEARS CONTACT LENSES
YES	NO	WEARS DENTAL APPLIANCE
YES	NO	HEARING PROBLEMS
YES	NO	ASTHMA
YES	NO	TROUBLE BREATHING DURING EXERCISE
YES	NO	HEART CONDITION
YES	NO	DIABETIC - TYPE 1 _____ TYPE 2 _____
YES	NO	MEDICATION
YES	NO	WEARS A MEDICAL INFORMATION BRACELET OR NECKLACE FOR WHAT PURPOSE? _____
YES	NO	HAS ANY HEALTH PROBLEM THAT WOULD INTERFERE WITH PARTICIPATION.

YES NO HAS HAD AN ILLNESS THAT LASTED MORE THAN A WEEK AND REQUIRED MEDICAL ATTENTION IN THE PAST YEAR
YES NO HAS HAD INJURIES REQUIRING MEDICAL ATTENTION IN THE PAST YEAR
YES NO HAS BEEN ADMITTED TO THE HOSPITAL IN THE PAST YEAR
YES NO SURGERY IN THE PAST YEAR
YES NO PRESENTLY INJURED. INJURED BODY PART _____
YES NO VACCINATIONS UP TO DATE
YES NO DATE OF LAST TETANUS SHOT: _____
YES NO HEPATITIS B VACCINATION

PLEASE GIVE DETAILS IF YOU ANSWERED "YES" TO ANY OF THE ABOVE.

<u>MEDICATIONS:</u>

ANY INFORMATION NOT COVERED ABOVE: _____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP STAYNER MINOR BASEBALL ASSOCIATION ADVISED OF ANY CHANGE IN THE ABOVE INFORMATION AS SOON AS POSSIBLE. IN THE EVENT OF A MEDICAL EMERGENCY AND THAT NO ONE CAN BE CONTACTED, TEAM MANAGEMENT WILL ARRANGE TO TAKE MY CHILD TO THE HOSPITAL OR A PHYSICIAN IF DEEMED NECESSARY.

I HEREBY AUTHORIZE THE PHYSICIAN AND NURSING STAFF TO UNDERTAKE EXAMINATION, INVESTIGATION AND NECESSARY TREATMENT OF MY CHILD.

I ALSO AUTHORIZE RELEASE OF INFORMATION TO APPROPRIATE PEOPLE (COACH, PHYSICIAN) AS DEEMED NECESSARY.

DATE: _____ SIGNATURE OF PARENT/GUARDIAN: _____