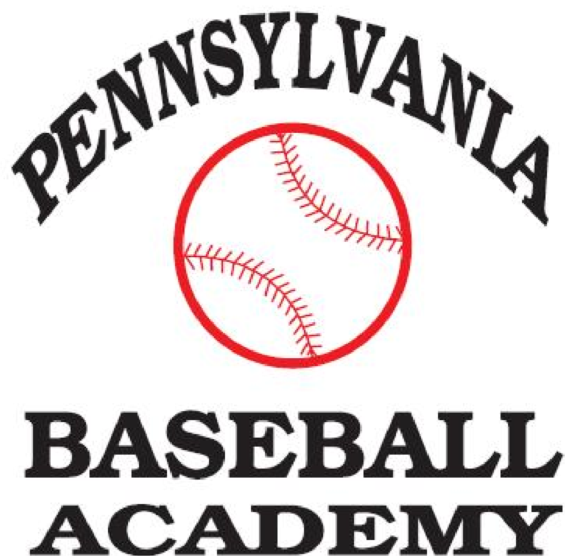

Check Dates you are attending	**Price**
_____ June 22nd-26th	
_____ July 13th -17th	$100 per Child for 1 week
_____ July 20th -24th	

Check Lunch option that Applies

____ Bring your own

____ Option A- 2 Slices of pizza, bag of chips and Gatorade for $20

____ Option B- 1 Slice of pizza, bag of chips and Gatorade for $12

You can mail or bring in your payment to the baseball academy. Cash or Check only, make checks payable to Pennsylvania Baseball Academy

Pennsylvania Baseball Academy
46 East Third Avenue
Collegeville, PA 19426
Phone: 610-489-1707
Fax: 610-489-1775
http://www.pennsylvaniabaseballacademy.com

HEALTH/MEDICAL REVIEW PART I—GENERAL INFORMATION AND AUTHORIZATIONS

CAMPER'S NAME:____
Last First Middle

CAMPER SOCIAL SECURITY #:_______-______-________DATE OF BIRTH:_____/_____/_________

BASIC PERSONAL INFORMATION

Parent/Legal Guardian: ____

Address: ____

Phone: Home (_____) _______________ Work (_____) _____________ Cell (_____) _______________

EMERGENCY CONTACT: _____________________________ Relationship:________________________

Phone: Home (_____) _______________ Work (_____) _____________ Cell (_____) _______________

INSURANCE INFORMATION

- **INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)**

Policy Holder: ____ Phone (_____) ______________

Address: ____

Insurance Co: ____ Phone (_____) ______________

Address: ____

ID#:___________________________________ Group#:____

Policy Holder's Employer: ______________________________________ Phone (_____) _________________

AUTHORIZATIONS

1. DO YOU GIVE PERMISSION FOR YOUR CHILD TO RECEIVE MEDICAL, DENTAL, OR PSYCHOLOGICAL SERVICES (INCLUDING OVER-THE-COUNTER MEDICATION AS NEEDED) UNDER THE SUPERVISION OF MEDICAL STAFF FOR ILLNESS AND ACCIDENTS THAT MAY ARISE WHILE AT CAMP?

   YES ______ NO ______

2. DO YOU GIVE PERMISSION FOR YOUR CHILD TO RECEIVE THE MEDICAL SERVICES OF A SPECIALIST?

   YES ______ NO ______

3. IN THE EVENT OF AN EMERGENCY AND YOU CANNOT BE CONTACTED, DO YOU GIVE PERMISSION FOR YOUR CHILD TO RECEIVE EMERGENCY MEDICAL TREATMENT AND/OR SURGICAL PROCEDURES THAT MAY REQUIRE THE USE OF AN ANESTHETIC?

   YES ______ NO ______

SIGNATURE OF PARENT/LEGAL GUARDIAN: ____**DATE:**____________

CAMPER NAME ____

Last First Middle

HEALTH/MEDICAL REVIEW PART II—PERSONAL MEDICAL HISTORY

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PERSONAL HISTORY

Please indicate if student has had any of the following:

_____Tuberculosis
_____Scarlet Fever
_____Measles
_____Rubella (German Measles)
_____Chicken Pox
_____Rheumatic Fever
_____Hepatitis
_____Malaria
_____Polio
_____Unexplained fever
_____Recent weight gain/loss
_____Eye trouble
_____Hearing loss
_____Sinus problems
_____Head trauma, concussion
_____Learning disability, ADD or ADHD

_____Chronic Rash
_____Anemia
_____Bleeding/Clotting Problems
_____Cancer/leukemia
_____Immune system problems
_____Heart Murmur
_____Heart palpitations
_____Chest pain/pressure
_____Chronic Cough
_____Shortness of breath
_____Abdominal pain
_____"Trick Knee" or other joint
_____Back Problems
_____Any orthopedic problems (sprains, strains, fractures)

_____Seizures
_____Dizziness
_____Fainting
_____Depression
_____Headaches
_____Asthma
_____ Other
____
____

COMMENT ON ANY CONDITIONS WHICH YOU HAVE CHECKED:

____
____
____
____
____

SURGERY: (include dates)

______________None

______________Appendectomy

______________Tonsillectomy

______________Hernia Repair

______________Arthroscopic surgery

______________Other__________________
____

ALLERGIES:

______________No known drug allergies

______________Hay fever

______________Bee stings—If yes, does camper have allergy injection kit?
______Yes ______No

______________Foods___________________________________
____

______________Other (please list)__________________________
____

ACCIDENTS, INJURIES, HOSPITALIZATIONS OR ILLNESS LASTING MORE THAN 5 DAYS (include dates) :

____
____
____

HEALTH/MEDICAL REVIEW PART II—PERSONAL MEDICAL HISTORY (Continued)

DOES THE CHILD WEAR GLASSES/CONTACT LENSES? (If yes, bring back-up pair of glasses/lenses if possible)

______ YES ______NO

PLEASE LIST THE NAME, ADDRESS, AND PHONE NUMBER OF ANY SPECIALIST CARING FOR CHILD: (Orthodontist, dentist, optometrist, allergist, etc.)

____

____

____

DRUG ALLERGIES: ____

____

____

HEALTH/MEDICAL REVIEW PART III- MEDICATIONS FORM

Prescription and Over-the-Counter Medications Form

Please Read the Following guidelines carefully:

1. All Medications (both prescription and over-the-counter) must be in the original container and properly labeled with camper's name, drug, dosage, and instructions.
2. All medications (both prescription and over-the-counter) must be listed on this form.
3. All medications (both prescription and over-the-counter) must be brought during check-in.
4. An authorized designee must dispense ALL medications. Self-medication is not permitted.
5. No student will be permitted to keep controlled substances in their possession during camp.

Name of Drug	Strength	Dose	Frequency

I certify that my child has had a physical examination by a licensed physician within the last six months and is free from any and all illnesses, injuries, or defects that would inhibit any and all participation in camp.

PARENT/GUARDIAN signature:____Date:____________