

PARTICIPANT PERMISSION/MEDICAL FORM

Mail to: PlayBall corp., 555 Central Park Ave 115, Scarsdale, NY 10583

The following information must be completed by parent or guardian of minors.

CAMPER: FULL NAME: _____ DOB: _____ AGE: _____ SEX: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 Parent:(legal guardian): _____ PHONE #: _____
 If not available in an emergency notify: _____ (Friend/Relative) PHONE #: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MEDICAL HISTORY: (indicate with an X - please give appropriate dates)

Physician Name: _____ Phone #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Last Examination: _____

DIAGNOSIS	YES	DATES	DIAGNOSIS	YES	DATES
Frequent Ear infections			German Measles		
Mononucleosis			Hay Fever		
Rheumatic Fever			Bleeding/Clotting		
Heart Defect/Disease			Mumps		
Chicken Pox			Poison Ivy		
Asthma			Hypertension		
Convulsions			Behavior		
Measles			Other		
Insect or Insect Bites			Other		
Diabetes					
Doctors Name/Signature					

Operations/Serious Injuries: (give dates): _____
 Disability or chronic/recurring illness: _____
 Are there any specific activities that should be limited or encouraged according to physician 's orders? (Yes/no): _____
 If yes please explain: _____
 Dietary Modifications: _____
 Current Medication(s) & Instruction(s): _____
 Hospital/Medical Insurance Carrier: _____ Policy / Group #: _____
 Insurance Company Address: _____ Phone #: _____

IMPORTANT - THIS SECTION MUST BE COMPLETED BEFORE ATTENDING CAMP/CLINIC

I hereby claim that am the legal guardian and that all information I have provided is accurate and that the person herein described has my permission to engage in all activities, except otherwise noted by me in writing. I hereby give permission to the medical personnel selected by the Camp Director to order X-Rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation. **In the event I cannot be reached in an emergency,** I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery. I understand that any pre-existing conditions or treatment required for situations as a result of pre-existing conditions will not be covered by the camp insurance.

Signature of Parent (legal guardian): _____ Date: _____
 Emergency Phone #: _____