# Mike Sheppard Baseball School

# Summer Camp Health Fact Sheet

CAMPER'S NAME _____ BIRTH DATE _____

ADDRESS _____

PARENT / GUARDIAN'S NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

EMERGENCY CONTACT (OTHER THAN PARENT / GUARDIAN) _____

RELATIONSHIP _____ PHONE _____

INSURANCE CARRIER _____ POLICY NUMBER _____

WEEK 1: _____ WEEK 2: _____ WEEK 3 : _____ WEEK 4: _____

WAIVER / RELEASE: I hereby agree to let my child participate in this camp. I understand that there are certain risks of injury inherent in the practice and play of these sports/activities, as well as in traveling and other related activities incidental to my participation, and am willing to assume these risks. I hereby certify that my child is fully capable of participating n the sports/activities, and that he / she is healthy and has no physical or mental disabilities or infirmities that would restrict full participation in this camp, except as included in writing in his / her application. In addition to giving full consent for my child's participation, I do hereby waive, release and hold harmless Mike Sheppard Baseball Camp Inc., it's officers, coaches, sponsors, partners, supervisors and representatives for any injury that may be suffered in my child in the normal course of participation in the sport and the activities incidental thereto, whether the result of negligence or any other cause. The law requires that parental permission be obtained for the procedures on minors. This release allows for such procedures to be promptly carried out, and so that no unnecessary delays will occur with operative procedures. HOWEVER, NO OPERATION WILL BE PERFORMED, EXCEPT IN AN EXTREME EMERGENCY, WITHOUT PARENTS BEING CONTACTED AND FULLY INFORMED. I grant the camp permission to use photographs of my child in future promotional materials.

DATE: _____ SIGNATURE: _____ RELATIONSHIP: _____

**PERSONAL HISTORY:** All medical information is strictly confidential. Please provide details of all positive answers under remarks.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Allergy to any medications (specify medication &reaction under remarks) | ☐ | ☐ | Seizure Disorder | ☐ | ☐ |
| Serious reaction to insect bites | ☐ | ☐ | Migraine Headaches | ☐ | ☐ |
| Hayfever, hives, seasonal allergies | ☐ | ☐ | Joint injury or disease | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Heart murmur or any other heart disorder | ☐ | ☐ | Disabling loss of vision, hearing | ☐ | ☐ |
| Kidney stones or history of kidney disease | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Thyroid or endocrine disorder | ☐ | ☐ | Anemia; including Sickle Cell Anemia | ☐ | ☐ |
| Colitis, irritable bowel or Crohn's Disease | ☐ | ☐ | | | |

PLEASE LIST ANY MEDICATIONSYOU USE ON A REGULAR BASIS(INCLUDE AMOUNT AND USAGE PER DAY) :_____

**PLEASE RETURN TO: Mike Sheppard's Baseball School, 28 Kayser Lane, West Orange, NJ 07052**

**O BE COMPLETED BY YOUR HEALTH CARE PROVIDER**

MUNIZATION HISTORY (Please booster according to ACIP guidelines)

. TETANUS-DIPHTHERIA month / day / year
Completed primary series of tetanus-diphtheria immunizations.....____/____/____

. M.M.R. (MEASLES, MUMPS, RUBELLA) if given instead of individual immunizations
1. ☐ Dose 1 – Immunized on or after first Birthday.....____/____/____
2. ☐ Dose 2 – Immunized at five years or later.....____/____/____

. MEASLES
1. ☐ Dose 1 – Immunized with live measles vaccine on or after the first birthday.....____/____/____
2. ☐ Dose 2 – Immunized at least one month after Dose 1 (Recommended by the State.....____/____/____
Department of Health, the ACHA, CDC, AAFP and AAP and required by SHU)

. RUBELLA
☐ Immunized with vaccine on or after first birthday.....____/____/____

. MUMPS (check appropriate box)
1. ☐ Had disease; confirmed by office record.....____/____/____
2. ☐ Immunized with vaccine on or after first birthday.....____/____/____

. POLIO (check appropriate box) Type of Vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
Complete primary series of Polio Immunization.....____/____/____

. TUBERCULOSIS PPD Applied_____ (must be within past year) ☐ Positive ☐ Negative
If PPD positive, please note chest x-ray date and results as well as INH dates under remarks below

Any History of reaction to food, serum, drugs, or medication? ☐ Yes ☐ NO
Explain_____

SEX_____ AGE_____ HEIGHT_____ WEIGHT_____ BP_____ PULSE_____ RESP_____
VISION: Uncorrected – Right 20 / _____ Left 20 / _____ With glasses / contacts - Right 20 / _____ Left 20 / _____
HEARING: Right Normal - ☐ Yes ☐ No Left Normal - ☐ Yes ☐ No Impairment_____

| | SYSTEM | SATISFACTORY | UNSATISFACTORY | DESCRIBE ABNORMALITY |
|---|---|---|---|---|
| 1 | Skin, Lymphatics | | | |
| 2 | Eyes | | | |
| 3 | Ears | | | |
| 4 | Nose, Throat | | | |
| 5 | Neck, Thyroid | | | |
| 6 | Chest, Breasts, Lungs | | | |
| 7 | Heart Rate / Rhythm | | | |
| 8 | Heart Murmur (describe) | | | |
| 9 | Abdomen, Liver, Kidneys, Spleen | | | |
| 10 | Hernia | | | |
| 11 | Genitalia | | | |
| 12 | Pelvic (if indicated) | | | |
| 13 | Rectal (if indicated) | | | |
| 14 | Extremities, Back, Spine | | | |
| 15 | Joints | | | |
| 16 | Neurological | | | |

The following abnormalities should be noted:_____

The applicant ☐ DOES ☐ DOES NOT have a history of emotional, psychological, or psychiatric disturbance
☐ Applicant may participate in camp activities: ☐ Without restriction ☐ With the following restriction_____
☐ Applicant should not participate in sports. Reason for limiting activity_____

HEALTH CARE PROVIDER (Please Print) NAME_____ PHONE_____

ADDRESS_____ SIGNATURE_____