BRAVEHEARTS BASEBALL CAMP
MEDICAL HISTORY
To be filled out by parent or guardian

Has Camper had any of the following:

HISTORY OF CHILDHOOD DISEASES	**YES**	**NO**	**PLEASE STATE ANY OTHER PERTINENT INFORMATION IN THE SPACE BELOW.**
CHICKEN POX			
GERMAN MEASLES			
MEASLES			
MUMPS			
WHOOPING COUGH			
HISTORY OTHER			
APPENDECTOMY			
BACK TROUBLE			
HERNIA OR RUPTURE			
MENINGITIS			
MONONUCLEOSIS			
SINUSITIS			
SLEEPWALKING			
SYMPTOMS, SIGNS			
BRACE BACK SUPPORT			
BONE JOINT OTHER PROBLEMS			
BRONCHITIS			
CHEST PAIN			
CHRONIC DIARRHEA			
EYE TROUBLE			
FAINTING CONVULSIONS			IS THERE AN ALLERGIC OR UNUSUAL REACTION TO MEDICATION OR DRUGS? IF YES, GIVE DETAILS INCLUDING THOSE MEDICATIONS THAT SHOULD BE GIVEN WITH UNUSUAL CARE.
FOOT TROUBLE			
FOOD SENSITIVITY			
HIGH BLOOD PRESSURE			
DISEASES			
ANEMIA			
ARTHRITIS			
CANCER			
COLITIS			
CONCUSSION			
DIABETES			
EPILEPSY OR OTHER SPASTIC CONDITIONS			
HEADACHES, MIGRAINES			
HEARING DIFFICULTY			
HEART TROUBLE, MURMUR			HAS SCHOOL ATTENDANCE BEEN INTERRUPTED BY ILLNESS ANY TIME LONGER THAN TWO WEEKS DURATION? IF YES, GIVE DETAILS.
HEPATITIS, LIVER TROUBLE			
KIDNEY TROUBLE			
POISON IVY			
NEUROLOGICAL OR MUSCULAR DISEASE			
RHEUMATIC FEVER			
RECTAL DISEASE			
TONSILECTOMY			
ULCER, STOMACH			
URINARY TRACT TROUBLE			
ASTHMA			INHALER? DETAILS:
BEE STING REACTION			DETAILS

Medication Order
To be completed by a Licensed Prescriber
Physician, Nurse Practitioner or others authorized by Chapter 94C

Name of Camper: _____ Date of Birth _____

Address _____

Name of Licensed Prescriber _____ Title _____

Business Telephone Number _____

Emergency Telephone Number _____

Medication _____

Route of Administration _____ Dosage _____

Frequency _____ Times of administration _____
(Please note when possible, medication scheduled at times other than camp hours.)

Specific directions or information for administration _____

Date of order _____ Discontinuation date _____

Diagnosis _____

Any other medical condition(s)* _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed

2. Other medication being taken by the student:

3. Consent for self administration Yes _____ No _____

Signature of Licensed Prescriber _____

*If not in violation of confidentiality

PHYSICIANS REPORT
PART B

NAME: _____ DATE: _____

GENERAL APPEARANCE: _____ HEIGHT: _____

POSTURE – SCREENING: _____ WEIGHT: _____

HEARING: L _____ R _____ BLOOD PRESSURE: _____

VISION: L _____ R _____

Skin-Acne, Psoriasis			
Scalp-eczema			
Eyes-Abnormality			
Ears-Abnormal drums **Cerium**			
Nose-Deviation of Septum **External deformities** **Polyps**			
Mouth **Inflamed Gums** **Obvious Caries** **Orthodontia**			
Throat **Enlarged Tonsils** **Diseased Tonsils** **Removed Tonsils**			
Glands			
Bronchi			
Lungs			
Thorax			
Heart			
Abdomen			
Back			
Extremities			
Feet			
Neurologic			
Anus			
Urinalysis	**Results**		
Tuberculin	**Date:**		
Results:			

IMMUNIZATION HISTORY

	DATE GIVEN
DPT DOSE 1	
DPT DOSE 2	
DPT DOSE 3	
MEASLES MMR 1	
RUBELLA MMR 2	
MUMPS	
POLIO DOSE 1	
POLIO DOSE 2	
POLIO DOSE 3	
POLIO DOSE 4	
BOOSTER IMMUNIZATIONS	
DPT-DOSE 4	
DPT-DOSE 5	
POLIO-DOSE	
OTHER-	

THIS PATIENT IS FIT FOR COMPETITIVE SPORTS
UNLESS NOTED OTHERWISE.

Physician's Signature: _____

Date: _____

Address: _____

Telephone Number: _____