# STARFIRES 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**<br>**Cerium** | | | |
| **Nose-Deviation of Septum**<br>**External deformities**<br>**Polyps** | | | |
| **Mouth**<br>**Inflamed Gums**<br>**Obvious Caries**<br>**Orthodontia** | | | |
| **Throat**<br>**Enlarged Tonsils**<br>**Diseased Tonsils**<br>**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: _____**