

Return form to:

Participant Name: _____
(Last) (First) (MI)

Elaine Sortino Softball School
c/o Planet Fastpitch
135 Ironstone St.
Uxbridge, MA 01569

MEDICAL AND IMMUNIZATION HISTORY PROGRAMS AND CAMPS

Section I: (To be completed by Parent or Guardian)

Name: _____ **Sex:** M F **Birth Date:** _____
Month/Day/Year

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

School Name: _____ **Program Dates:** _____ to _____ **Soc. Sec.:** ____ - ____ - _____

Father: _____ **Telephone:** _____ **Telephone:** _____
(Day Time) (Evening)

Mother: _____ **Telephone:** _____ **Telephone:** _____
(Day Time) (Evening)

Guardian is: Father: _____ Mother: _____ **Other (Name & Address):** _____
Telephone Number: _____

In case of illness or emergency the name and telephone number of a person to contact: (Relation to participant)

Family Physician or HMO (Name and Address): _____
Family Physician or HMO Telephone Number: _____

Family Dentist (Name and Address): _____
Family Dentist Telephone Number: _____

Medical Insurance Company Name: _____ **Policy Number:** _____

In case of emergency, I hereby give permission to the University Health Service staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child as named above.

Date: _____ **Parent/Guardian Signature:** _____

Section II:

Physical Examination: (Must be in the preceding 12 months and done by a Medical Provider)

Medical History: (Please note significant disorders)

Allergies _____	Heart _____	Tuberculosis _____
Allergies _____	Kidney _____	Whooping Cough _____
Diabetes _____	Lung _____	Varicella _____
Disabilities _____	Neurological _____	Other _____

Pertinent Medical History:

