Return form to:

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

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

Mother: _____ **Telephone:** _____ (Day Time) **Telephone:** _____ (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 _____
Allergies _____
Diabetes _____
Disabilities _____

Heart _____
Kidney _____
Lung _____
Neurological _____

Tuberculosis _____
Whooping Cough _____
Varicella _____
Other _____

_____
Pertinent Medical History:

Child Name: _____ **Sex:** M F **Birth date:** _____

Section III: _____

Summary of Significant Treatment Program Including Names/Doses of Medications to be used while at program:
(Medications **MUST** be in a container with the original label)

_____

Section IV: Immunizations _____

Immunization	**Dates**	**Immunizations**	**Dates**
Has completed primary series of tetanus/diphtheria? (Four Doses) Yes_____ No_____			
Completed primary series of polio immunization? Yes _____ No _____ Primary Series – Type of vaccine: OPV IPV E-IPV _____/_____/_____. Last Booster – Type of vaccine: OPV IPV E-IPV _____/_____/_____.			
Diptheria/Tetanus (Td) Must be competed within last 10 years (Complete only if primary series was more than 10 years ago.	Month / Day / Year _____/____/_____	Mumps or MMR # 1 Must be **AFTER** age 12 Months Or Positive Mumps Titer (blood test)	Month/Day/Year _____/_____/_____. Month/Day/Year _____/_____/_____
Measles #1 (Rubeola, Red Measles) – Must be **AFTER** age 12 months or MMR # 1 Or Positive Measles Titer (blood test)	Month / Day / Year _____/____/_____. Month / Day / Year _____/____/_____. Month / Day / Year _____/____/_____.	Rubella or MMR#1 (German Measles) – Must be **AFTER** age 12 months or Rubella Titer (blood test)	Month / Day / Year _____/____/_____. Month / Day / Year _____/____/_____.
Measles #2 (Rubeola, Red Measles) – Must be at least 30 days **AFTER** first dose. Or MMR # 2	Month / Day / Year _____/____/_____. Month / Day / Year _____/____/_____.	Hepatitus B Those born **AFTER** 1-1-92 Dose #1 Dose #2 Dose #3	Month / Day / Year _____/____/_____. Month / Day / Year _____/____/_____. Month / Day / Year _____/____/_____.
Medical exemption: The above named person does not have one or more of the required immunizations because he/she has a medical probem that precludes the _____ vaccine(s).			

Health Care Provider Signature and/or stamp: _____ Date: _____

Printed Names: _____

Address: _____ Telephone: _____