

MEDICAL CLEARANCE FORM



This form must be completed, signed and processed before you will be allowed to participate in camp.

- **Participants:** Please complete and sign Section 1 of this form, and please have your health care provider complete and sign Section 2 of this form.
- **Health Care Providers:** Please review Section 1 of this form and then complete and sign Section 2 of this form.

SECTION 1: TO BE COMPLETED BY PARTICIPANT

Last Name: _____		First Name: _____		M ☐	F ☐
Date of Birth: / /		Home Phone: () _____			
Address: _____		_____			
Street		City	State	Zip	
Emergency Contact 1: _____		Relationship: _____			
Home Phone: () _____		Bus. Phone: () _____		Cell: () _____	
Emergency Contact 2: _____		Relationship: _____			
Home Phone: () _____		Bus. Phone: () _____		Cell: () _____	

General Questions: Please check “Yes” or “No” for the following questions. Explain any “Yes” answers below, noting the number of the question(s).

	Yes	No
1. Are you presently taking a blood thinning medication or any medication that affects your body’s ability to stop bleeding?	☐	☐
2. Have you ever been diagnosed with a cardiac condition?	☐	☐
3. Have you ever had high blood pressure?	☐	☐
4. Have you ever had a stroke/TIA?	☐	☐
5. Do you have diabetes?	☐	☐
6. Have you ever had a chronic or recurring illness/condition?	☐	☐
7. Have you had surgery in the past 5 years?	☐	☐
8. Do you have asthma?	☐	☐
9. Have you ever passed out or been dizzy during or after exercise?	☐	☐
10. Have you ever had chest pain during or after exercise?	☐	☐
11. Have you ever had seizures?	☐	☐
12. Have you ever had problems with joints (i.e. knees, ankles)?	☐	☐
13. Have you ever had back problems?	☐	☐

Please Comment: _____

Participants are responsible for providing updated information to our Director of Nursing about any changes in health status.

Participant’s Signature: _____ Date: // _____



Camper Name: _____ DOB: _____ Home Phone: () _____

SECTION 2: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

Height	Weight	Blood Pressure	Date of last Tetanus Shot
ft. in.	lbs.	/	/ /

Does this patient have any of the following allergies?

- | | |
|--|---|
| ☐ Food; Reaction: _____ | ☐ Latex; Reaction: _____ |
| ☐ Insect Venom; Reaction: _____ | ☐ Drug; Reaction: _____ |
| ☐ Seasonal; Reaction: _____ | ☐ Other; Reaction: _____ |

Please explain any allergy in detail:

Does this patient have any dietary restrictions? ☐ YES ☐ NO

If yes, please explain:

Is this patient taking any medication(s) either prescription or over-the-counter? ☐ YES ☐ NO

If yes, please indicate:

Medication(s): _____ Dosage/Frequency: _____ Indication: _____

Please provide us with any additional information about this patient's health that we should be aware of:

Please let us know of any hospitalizations, operations, injuries, special restrictions or limitations:

Provide Medical Insurance Plan Information (Carrier/Plan #):

I agree that my patient is in good health and that he/she can participate in the Phantasy Camp Baseball Program at the following level:

- ☐ Full Activity ☐ Limited Activity (please list limitations below)

The above mentioned participant has undergone a health evaluation within the past year and may participate (as noted above) in Phantasy Camp Baseball Programs.

Date: _____

Health Care Provider's Name: _____

Health Care Provider's Signature: _____

Telephone Number: _____

If you would like to speak to someone from our camp, please call (610) 520-3400.

Physician Name & Address: (Please use a stamp or print)

