Medical History and Release

This information will be kept by Head Athletic Trainer or Dorm Counselor, and consulted anytime a medical problem arises during the Texas Tech Softball Camps. Note: Medications brought from home that are not listed on this form will not be permitted.

Name: _____ Date of Birth: /_____/_____

Phone: (_____)_____

Address (City/State/Zip): _____

Date of Last Immunizations: _____

Allergies Identify: _____

Food Allergies, Identify: _____

Are there any condition(s) that will restrict activity? _ If yes, explain and give instructions: _____

_____

If taking regular medication, give name(s) of medication and directions for dosage: _____

_____

_____

_____

Please check if subject to: Fainting _____ Nosebleeds _____ Headaches _____

Other _____

If necessary, administer: Aspirin _____ and/or Tylenol _____ How much and how often: _____

_____

Vision corrected by: Glasses _____ Contact lenses _____

Teeth corrected by: Braces __ Headgear _____ Retainers _____ Other _____

_____

General Information

We will utilize the Texas Tech Infirmary or the emergency room of University Medical Center, unless you specify otherwise. If hospital treatment is necessary, we will immediately contact the individuals listed on the Emergency Information form. No Medical/Hospitalization Insurance is carried through this program. Parents/Guardians will be billed for any and all medical expenses incurred by their children during the Texas Tech Softball Camps including but not limited to emergency room costs, Physician fees, X-rays, medication, pharmaceuticals and related expenses.

Consent to Treat

I authorize program administrators of the Texas Tech Softball Camps to sanction medical treatment for (participant's name) _____. I understand that NO medical/hospitalization insurance is carried through Texas Tech Softball Camps and agree to be responsible for all medical expenses incurred by my child while attending the Texas Tech Softball Camps.

Parent/Guardian

_____ _____

Print Signature Date

Insurance and Emergency Information

Please fill in every line. If necessary, write N/A for No Applicable

Parents' Medical/Hospitalization Carrier (give name of insurance company, not agent):

_____

Policy Number: _____

Family Physician: _____

Office Address: _____

Office Phone: _____

Preferred Lubbock Physician, (optional) _____ Phone: _____

In Case of Emergency Contact:

Parent/Guardian: _____

Address (City/State/Zip): _____

Home Phone: _____ Office Phone: _____

If the above cannot be contacted, call (please list at least two):

Name: _____

Address (City/State/Zip): _____

Home Phone: _____ Office Phone: _____

Relationship to participant: _____

Name: _____

Address (City/State/Zip): _____

Home Phone: _____ Office Phone: _____

Relationship to participant: _____

Name: _____

Address (City/State/Zip): _____

Home Phone: _____ Office Phone: _____

Relationship to participant: _____

Texas Tech Softball Camps Release / Agreement Form
Parent Approval for Media Coverage Participation

(Please Print Clearly)

Media Coverage

Name of Athlete_____

I hereby give permission for the athlete listed above to be released to the media and for his/ her participation in any media coverage which might transpire during the course of this program.

Signature of Parent/Guardian_____ Date_____

Program Rules and Disciplinary Procedures

We, the parent(s)/guardian(s) and participant, agree to abide by the rules and regulations and sanctions of this program as detailed in the Camp Orientation. We understand that there will be no refund of fees in the event of disciplinary expulsion.

Signature of Parent/Guardian_____ Date_____

Agreement to Hold Harmless

I, _____, understand that my child, _____ has the opportunity to participate in the Texas Tech Softball Camps program for students wishing to improve skills and interest in softball sponsored by Texas Tech University. I hereby affirm that I desire to have my child participate in said program. I agree to and I do hereby release, hold harmless, and indemnify Texas Tech University, Board of Regents, the Department of Athletics and employees for any injury that may occur during his/her participation in said program.

Signature of Parent/Guardian_____ Date_____

TEXAS TECH UNIVERSITY ATHLETIC PHYSICAL

NAME_____ SEX _____ AGE_____ DATE OF BIRTH _____

R NUMBER _____ SPORT _____

SIGNATURE: _____ DATE OF EXAM: _____

_____

_____

MEDICAL/PHYSICAL EXAM:

HEIGHT _____ WEIGHT _____ BP_____/_____ PULSE _____

VISION: RIGHT 20/_____ LEFT 20/_____ CORRECTED YES / NO DENTAL: WNL F/U

	NORMAL	ABNORMAL FINDINGS
Heart		
Pulses		
Lungs		
E.N.T.		
Abdomen		
Genitalia (Males)		
Musculoskeletal		

CLEARANCE:

A. Cleared

B. Cleared after completing evaluations/rehabilitation for:_____

C. Not Cleared Due To: _____

Recommendation:_____

_____

Name of Physician:_____ Date: _____

Address:_____ Phone: _____

Signature of Physician:_____ M.D. or D.O.

NAME_____ EXAM DATE _____

(LAST) (FIRST) (M.I.)

R NUMBER _____ DATE OF BIRTH _____

	WNL	INITIALS	FINDINGS
CERVICAL Impingement Signs Compression Test Weakness			MD Intials _____
THORACIC/ LUMBAR SPINE EXAM (+) Straight Leg Raise ROM Peristent LBP			MD Initials_____
SHOULDER (R&L) EXAM ROM INSTABILITY AC/CLAVICLE STRENGTH			MD Initials _____

NAME _____ EXAM DATE_____

(LAST) (FIRST) (M.I)

R NUMBER_____ DATE OF BIRTH _____

ELBOW (R&L) EXAM ROM INSTABILITY STRENGTH MD Initials _____			
	WNL		
FOREARM/WRIST/ HAND/ FINGERS (R &L) EXAM ROM INSTABILITY STRENGTH MD Initials_____			
	WNL		FINDINGS
PELVIS / HIPS /ABDOMEN EXAM ROM STRENGTH PAIN MD Intials _____			

NAME _____ EXAM DATE _____
(LAST) (FIRST) (M.I.)

R NUMBER_____ DATE OF BIRTH _____

THIGH/ HAMSTRING (R&L) EXAM ROM STRENGTH MD Initials _____			
KNEE (R&L) EXAM ROM INSTABILITY STRENGTH MD Initials_____			
FOOT / ANKLE (R &L) EXAM ROM INSTABILITY STRENGTH MD Initials _____			

ADDITIONAL NOTES/RECOMMENDATIONS