

The Miracle League of Corpus Christi (Form is good for 3yrs)
Player's Medical History and Physician's Statement:

Player's Name: _____ Date of Birth: _____

Home Address: _____

Name of Parent/Guardian: _____

Medical Diagnosis: _____

Medical Information:

Tetanus Shot: no yes, date of last shot: _____

Seizures: no yes

If yes, are seizures controlled by medication? _____

Date of last seizure: _____

Medications player is currently taking: _____

Please indicate if the player has a problem and/or surgeries in any of the following areas by checking YES. If YES please comment:

AREA	Yes	Comments
Auditory		
Visual		
Speech		
Circulatory/Cardiac		
Pulmonary/respiratory/asthma		
Neurological		
Muscular		
Orthopedic		
Allergies		
Learning Disability		
Mental Impairment		
Psychological Impairment/behavioral		
Other		

Mobility:

Please indicate the player's primary mode for moving in the community:

- walking independently
- walking with help from caregiver
- walking using an assistive device (ie. walker, crutches)
- wheelchair user

Please indicate any other special precautions or equipment used by player when moving in community settings: _____

Physician Statement – signature required:

To my knowledge, there is no reason why this child cannot participate in supervised baseball games for children with disabilities.

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____

Address of Physician's office: _____

Phone: _____