OAKLAND BASEBALL CAMPS, LLC
Camp Medical Information and Release for Treatment

Date of Camp:______________________________

Child's Name:______________________________ Date of Birth:____________________

Parent(s)/Guardian(s) Name:____

Home Address:____

Telephone #:______________________Work #:_______________________ Cell #:__________________

Secondary Contact Source in Case of Emergency: Name____

Telephone #:______________________Work #:_______________________Cell#:___________________

***If my Child needs medical treatment while participating at Oakland Baseball Camps, I give my permission for treatment to be given immediately.

Parent/Guardian Signature:____ Date:___________________

Parent/Guardian Signature:____Date:____________________

Insurance Information

Insurance Co:_____________________________ Member's Name:_________________________________

Group #:_________________________________ Policy #:_____________________________________

ID #:____________________________________ Service Code:_________________________________

Medical Information

1) If your child is presently taking any medication, please indicate what type and why:____
2) Please list any drug sensitivities:____
3) Please list any allergies:____
4) Please list your child's medical problems and/or significant injuries that the medical staff at Oakland Baseball Camps should be made aware of:____
____

Thank you for your cooperation in filling out this important emergency information.