



**RAY REID SOCCER SCHOOL MEDICAL RELEASE FORM**

HEALTH EXAM/RECORD FOR CAMPER'S AND STAFF

Physical Exams Are Valid for 2 Years From Date of Last Examination;

Physical **must be signed** by a PA, APRN or physician within the last 24 months

FAX TO: RAY REID SOCCER SCHOOL 860.674.1704

Camper  Staff

**FORM MUST BE SUBMITTED BY JUNE 1, 2012**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Date of Arrival at Camp \_\_\_\_/\_\_\_\_/\_\_\_\_ Departure Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:** Date of Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ May participate in all camp activities

\_\_\_\_ May participate except for \_\_\_\_\_

Medical information pertinent to routine care and emergencies \_\_\_\_\_

Is this individual taking prescription medication?  Yes  No  
If yes, indicate prescription \_\_\_\_\_

Does the individual have allergies?  Yes  No Explain \_\_\_\_\_

Is the individual on a special diet?  Yes  No Explain \_\_\_\_\_

May administer over the counter medication per camp nurse and physician  
 Yes  No Explain \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices (**IMPORTANT: please attach copy of vaccination records or specify current vaccinations in the chart below**):


Comments \_\_\_\_\_

Print name of medical care provider \_\_\_\_\_

Medical care provider's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature of Physician, APRN or PA \_\_\_\_\_

Date Form Signed \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone Number \_\_\_\_\_