RAY REID SOCCER SCHOOL MEDICAL RELEASE FORM
HEALTH EXAM/RECORD FOR CAMPERS AND STAFF
*Physical Exams are **valid for 2 Years** from date of last examination;*
*Physical Exams **must be signed** by a PA, APRN or physician within the last 24 months*

EMAIL TO: info@RayReid.com or FAX TO: 860-674-1704

☐ Camper ☐ Staff **FORM MUST BE SUBMITTED BY JUNE 1, 2019**

Camper Name: _____ Date of Birth: ____/_____/_____

Date of Arrival at Camp: ____/_____/_____ Departure Date: ____/_____/_____

Parent/Guardian Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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 medical history and/or emergencies: _____

_____

Does this individual take prescription medication?: ☐ Yes ☐ No
If yes, please see Ray Reid Soccer School Authorization to Administer Medication Form

Does this individual use an inhaler, EPI Pen or any other life saving device/medication?: ☐ Yes ☐ No
If yes, please see Ray Reid Soccer School Authorization to Administer Medication Form

Does the individual have allergies?: ☐ Yes ☐ No Explain: _____

Is the individual on a special diet?: ☐ 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 (I**MPORTANT: please attach copy of vaccination records or specify current vaccinations in the chart below; *we cannot accept a notation of "up-to-date" or "current"***):

Comments: _____

_____

Medical Care Provider's Address: _____

City: _____ State: _____ Zip: _____

Date Form Signed: ____/_____/_____ Telephone Number: _____

Print Name of Physician, APRN or PA: _____

Signature of Physician, APRN or PA: _____