



**CHRIS GBANDI SOCCER ACADEMY MEDICAL RELEASE FORM
HEALTH EXAM/RECORD FOR CAMPERS AND STAFF**

Physical Exams are valid for 3 Years from date of last examination;
Physical Exams **must be signed** by a PA, APRN or physician within the last 36 months

Please Return Completed Form to the Camp prior to your camper/s attending camp

Email to: camps@chrisgbandisoccer.com

Camper

Staff

Camper Name: _____ Date of Birth: _____

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

Parent/Guardian Name: _____ Phone: _____

Guardian Address: _____

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 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 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 (**IMPORTANT: 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"**):

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

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: _____