MEDICAL RECORD / HEALTH EXAM / MEDICAL RELEASE

Every camper must have this health record filled out and bring it with them to camp check-in
This form is to be completed and signed by a physician before your child can participate.
An attached physician's signed physical dated within two years from the start of camp will suffice, with the Parent/Guardian portion of this form completed
PLEASE DO NOT MAIL AHEAD

This section is to be completed by parent or guardian

Participant / Guardian(s) / emergency contact info

Date attending: _____ Site's Name:_____

Participant Name:_____

Date of birth: _____ Age: _____

Address:_____

City/State/Zip: _____

E-mail: _____

Guardian 1 (Name)_____

Phone1:_____

Guardian 2 (name):_____

Phone 2_____

Emergency contact

person (name): _____

Relationship to the participant: _____

Phone: _____

Insurance Information

Health Insurance

Provider_____

Policy/ID Number_____

Policy Holder's Name _____

Policy Holder's DOB _____

Insurance Provider Contact: Phone:_____

Please list any medical problems we should be aware of while the participant is at camp (example: allergies, emotional illness or disorder, etc.). _____

_____

_____

Medication(s) being taken: (please list and explain)

_____

_____

_____

Parent's Authorization

I warrant and represent **to My Mobile Soccer Academy (KidsAfrik Inc.)** That I am the parent and/or guardian of the listed participant and that I am authorized to execute this Consent and Release on behalf of my minor child. I hereby request you (MSSA/KIDSAFRIK Inc.) accept this agreement for my child's enrollment in the event listed on this form. In consideration of you (MSSA/KIDSAFRIK Inc.) acceptance of this agreement, I hereby agree to release, hold harmless, and indemnify you (MSSA/KIDSAFRIK Inc.), and all of their respective owners, agents, employees, sponsors, representatives and assigns, from and for any and all claims resulting from any injuries or death sustained by my child while participating in the Events, or in traveling to or from the Events. I acknowledge that soccer and other activities in the event could be contact activities, and understand that, although rare, there is a risk of serious injury or death associated in playing the activities. I hereby give permission to the coaches, training staff, and other medical professionals to provide medical care as deemed necessary to my child in case of any injury or illness and I agree that I will be financially responsible for the cost of same. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I acknowledge and agree that I am responsible for outfitting my child with the appropriate equipment (cleats, shin pads, mouth guard) for the activities, and I agree that my child will their shin pads and mouth guard at all times during the Events. I also acknowledge that GBL has provided me with a link in the registration packet to further information on concussions in sports. Parent

Signature _____

Date _____

NOTEMedication will be checked and kept by staff. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The "prescribers authorization form" must accompany all medication and requires the physician's signature. Administration of Medication Form must accompany all medication for camps. please contact us in advance. Inhalers for allergies or Epi-pen punches should be kept with participants at all times.

To be completed by physician

Today's date: _____

Camper's Name: _____ Date of birth: _____

Date of last physical examination (must be within last 24 mos.) _____

Medical history: (circle any that apply)

Chickenpox	Hay Fever	Earaches	German Measles
Sinus Problems	Whooping Cough	Heart problems	Glasses
Bee sting allergy	Diabetes	Drug allergy (specify)	Contacts
Seizures	Food allergy (specify)		

(Please note significant disorders, treatments or special restrictions)

_____

_____

Medications: (please list)

_____

Immunizations: All must show dates

	Date 1st dose	Date 2nd dose	Date 3rd dose	Date 4th dose	Date 5th dose	
DTP/DtaP/DT						
OPV/1PV						
MMR						
Measles						
Hib (Haemophilus Influenza Type B)						
Hepatitis B						
Varicella (Chicken Pox) (Recommended)						
Other						

The above named person is in satisfactory condition and may engage in all camp activities except as noted.

____May Participate in all camp activities

____May participate except for_____

Physician'sSignature*_____

Physician's Name_____ Date_____

Address_____ Phone_____