

# 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 KA has provided me with a link in the registration packet to further information on concussions in sports. Parent

Signature \_\_\_\_\_

Date \_\_\_\_\_

\*\*\*NOTE\*\*\* Medication 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)

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Medications: (please list)

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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's Signature\* \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_