AARON'S ACRES PHYSICIAN'S MEDICAL RELEASE
PLEASE RETURN BEFORE April 15th, 2026
ALL AREAS MUST BE COMPLETED BEFORE SUBMITTING.

Participant's Name:_____**Date of Birth:** _____

Participant's Address: _____

_____

Parent's Name and Phone Number: _____

This section to be completed by Participant's Physician

Diagnosis: _____

_____

_____

Are all immunizations up to date? (**Please attach immunization record**) _____

Date of Most Recent Tetanus Booster: _____

Allergies (food, drug, insect, asthma): _____

Dietary Restrictions: _____

Medication List:

Medication(s) *	Dosage Amount	Reason for Medication(s)	Hour(s) or Time(s) to be Dispensed

Effective Dates: (current year only) From:_____ To: _____

Specific Activities Restricted:_____

_____

Any other areas of concern we should be aware of: _____

_____

I have examined the above child and found the child to be fit to be admitted to the Aaron's Acres program and participate in all activities without risk to the child and to others.

Physician's Name:_____Date: _____

Address: _____

_____

Phone:_____Physician's Signature: _____

Please attach immunization record