PHYSICIAN'S MEDICAL RELEASE

ALL AREAS MUST BE COMPLETED BEFORE SUBMITTING.
PLEASE ATTACH IMMUNIZATION RECORDS

Participant's Name: _____ Date of Birth: _____

Participant's Address: _____

Parent's Name and Phone Number: _____

This section to be completed by the Participant's Physician:

Diagnosis/es:_____
_____
_____

Are all immunizations up to date? ☐ YES ☐ NO Date of Last Tetanus Booster: _____
Allergies (food, drug, insect, asthma): _____
_____

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

Effective Dates (current year only) From: _____ To: _____
Specific Activity Restrictions:_____
_____

Any other areas of concern that we should be aware of: ☐ YES ☐ NO

If yes: _____
_____

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: _____

This form is to be completed by April 15th for Summer Camp and September 15th for School Year Programs.