All Out Soccer Camp, LLC: 148 Winthrop Street, Holliston, MA 01746: Phone 508-808-3068

Physical & Immunization Form

Name ________________________________Date of birth _____ / ______Gender: Male / Female (circle)

Age ______ years _____ months Blood Pressure____________ Height ________Weight ________

IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DPT (Diphtheria, Pertussis, Tetanus)					
TD (Tetanus, Diphththeria)					
Tetanus					
Polio					
MMR (measles, Mumps, rubella)					
Hepatitis B					
Varicella (Chicken Pox)					
Hib (Haemophiles influenza)					
Tuberculin Test Results					
Lead Test Results					
Other					

CHECK IF NORMAL OR GIVE DETAILS

Eyes ____________ Vision _________Skin ________Throat ________Ears_______Hearing_________

Teeth________Heart __________Lungs_______Posture _______Musc/Skel ________CNS _________

Genitalia __________ Menstruation _____Hernia ________________ Abdomen __________

KNOWN ALLERGIES AND TREATMENT

Food ____

Medication(s)____

Environment ____

Insect(s)____

Is the person currently under the care of a physician? . Yes . No If yes, why?__________________________________

Current medications or treatment____

Recommend/describe any limitations or restrictions on camp activities____

Medications to be taken/administered at camp: (including sunscreen, inhalers, or the like.)

Name of Medication(s) ____

MEDICATION POLICY
Please list ALL prescription medication, and any over-the-counter or nonprescription drugs, taken routinely. A sufficient supply of medication (enough to last the entire enrollment at camp) must be brought to the nurse. Please remember to keep the medication in the original, packaged container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. A Medical Authorization Form must be signed by the parent.

Additional health information ____

I have examined this child herein described and it is my opinion that this child is able to engage in and participate in all camp activities, unless otherwise noted above.

Licensed physician's signature ____

Address ________________________________Telephone ________________________ Examination date___________
(Must be within 13 months of starting camp.)