IMMUNIZATION HISTORY

Child's Name_____________________________________ Team Name____________________________________

Vaccine Date of basic immunization / Date of last booster

DPT___________/_____________ Polio ___________/_____________ MMR _____________/_______________

THE FOLLLOWING PORTION OF THIS FORM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT:

I have examined the above applicant of the Golden Goal WITHIN THE LAST YEAR. (DATE EXAMINED_____________) In my opinion, the applicants condition does_____/ does not_______ preclude Golden Goal activities and programs. The applicant is under the care of a physician for the following condition(s)

____

____

Current Treatment (include current medications):

____

____

Explanation of any reported loss of consciousness, convulsions or concussions:

____

____

Does applicant have epilepsy? Yes______ No_______ Does applicant have diabetes? Yes______ No________

Recommendations and restrictions while at Golden Goal:

____

____

Any medications to be administered at Golden Goal (state specific dosage):

____

____

Any medically prescribed meal plan or dietary restrictions:

____

____

Any allergies (food, drug, plants or insects, etc.)

____

____

Any additional health information:

____

____

Licensed provider's signature____________________________________

Name (printed)___________________________________ Date_________________________

Address ____ Phone #___________________________

If you have any questions regarding the medical form or requirements, please email info@goldengoalpark.com or call 888-909-6688.