



2010 Camp STIX Physician's Release

(To be completed by health care provider)

This form is REQUIRED for all campers and must be returned to the camp office by June 10.

Camper's Name: _____

Allergies: _____

Type of reactions: _____

Medications (both over the counter and prescription) (other than insulin):

General condition: _____

Other medical problems: _____

Weight: _____ Height: _____

Normal: (check)

Abnormal: (describe below)

- | | | | |
|-------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Oral Cavity | <input type="checkbox"/> Heart | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Neck | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Lymphatic |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Genitalia | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Back | <input type="checkbox"/> Extremities | |

Notes about abnormalities: _____

HgA1c/Glycosylated Hemoglobin: _____ Date: _____

Other Lab: _____

Restrictions and/or comments: _____

PLEASE NOTE: THIS IS AN EXTREMELY ACTIVE CAMP. WE NEED TO KNOW OF ANY PHYSICAL CHALLENGES THAT COULD IMPEDE THIS CAMPER'S ABILITY TO PARTICIPATE ACTIVELY. WE EXPECT CAMPERS TO BE INDEPENDENT IN ACTIVITIES OR DAILY LIVING, AND BE ABLE TO COMPLETE ACTIVITIES OF DAILY LIVING IN FIFTEEN (15) MINUTES OR LESS.

This child has my permission to attend Camp STIX. (Signature required or child will not be allowed to stay at Camp STIX)

Physician's Signature _____ Date

Physician's Name: (please print) _____

Address: _____

Phone: _____

01/10 lw