



## 2010 Camp STIX Physician's Release for Volunteers

(To be completed by health care provider)

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

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 VOLUNTEER'S ABILITY TO PARTICIPATE ACTIVELY.**

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name: (please print) \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

01/10 lw