Camp STIX Volunteer – Physician's Release

(To be completed by health care provider)

This form is REQUIRED for all volunteers and must be returned by April 1st

Name of Volunteer: _____ DOB: ____/____/_____

Camp Name: _____ Camp Department (circle one): MASH Program DISH Support

Notable Medical Problems: _____

Allergies (food or drug) and type(s) of reactions: _____

Specialty Diet or Food Preferences: _____

Medications (both over the counter and prescription): _____

_____

Date of last tetanus: _____ Are Immunizations current? YES / NO

Physical Examinations: Blood Pressure: _____ Weight: _____ Height: _____

Normal: (check) Abnormal: (describe below) Date of Exam (if different from completion date): _____

❑ General	❑ Nose	❑ Lungs	❑ Skin
❑ Head	❑ Mouth	❑ Abdomen	❑ Extremities
❑ Eyes	❑ Neck	❑ Musculoskeletal	❑ Psych
❑ Ears	❑ Heart	❑ Neurological	❑ _____

Notes about abnormalities: _____

_____

May this individual actively participate in camp activities without limitations? YES / NO If no, please explain: _____

_____

Diabetes Information (if applicable): Last Hemoglobin A1c: _____ Date: _____

Current diabetes regimen: Types of Insulin Used: _____ Type of Insulin Pump: _____

Any specific tasks or goals that this individual needs help with: _____

Other information for Medical Staff: _____

_____

_____

PLEASE NOTE: THIS IS A VERY ACTIVE CAMP. WE NEED TO KNOW OF ANY PHYSICAL, SOCIAL OR EMOTIONAL DIFFICULTIES WHICH COULD IMPEDE FULL PARTICIPATION.

This individual is medically cleared to participate at Camp STIX. Date: _____

Provider's Signature/Title: _____ Provider's Name (print): _____

Provider's Address: _____ Provider's Phone: _____

STIX Diabetes Programs ▪ PO Box 8308 Spokane, WA 99203 ▪ (509) 484-1366 ▪ campstix@campstix.org

Fax completed form to (509) 955-1329 attn: Camp STIX Medical Director