



## Camp STIX Camper – Physician’s Release

(To be completed by health care provider)

This form is REQUIRED for all campers and must be returned by June 1st

Name of camper: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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): \_\_\_\_\_

- |                                  |                                |  |                                      |
|----------------------------------|--------------------------------|--|--------------------------------------|
| <input type="checkbox"/> General | <input type="checkbox"/> Nose  | <input type="checkbox"/> Lungs           | <input type="checkbox"/> Skin        |
| <input type="checkbox"/> Head    | <input type="checkbox"/> Mouth | <input type="checkbox"/> Abdomen         | <input type="checkbox"/> Extremities |
| <input type="checkbox"/> Eyes    | <input type="checkbox"/> Neck  | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Psych       |
| <input type="checkbox"/> Ears    | <input type="checkbox"/> Heart | <input type="checkbox"/> Neurological    | <input type="checkbox"/> _____       |

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: \_\_\_\_\_