Camp STIX participant – 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 (over the counter and prescription): ____

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Date of last tetanus: _____________ Date of MMR shot: ______________________ 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
- ❑ Head
- ❑ Eyes
- ❑ Ears
- ❑ Nose
- ❑ Mouth
- ❑ Neck
- ❑ Heart
- ❑ Lungs
- ❑ Abdomen
- ❑ Musculoskeletal
- ❑ Neurological
- ❑ Skin
- ❑ Extremities
- ❑ Psych
- ❑ ______________________

Notes about abnormalities: ____

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

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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: ____

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PLEASE NOTE: THIS IS A VERY ACTIVE 6 DAY CAMP. WE NEED TO KNOW OF ANY PHYSICAL, SOCIAL OR EMOTIONAL DIFFICULTIES WHICH COULD IMPEDE FULL PARTICIPATION.

Sign below if this individual is medically cleared to participate at Camp STIX. Date: ________________________

Provider's Name/Title: ____ Provider's Signature: ______________________

Provider's Address: ____ Provider's Phone: _______________________