



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 28th

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): _____

- | | | | |
|----------------------------------|--------------------------------|--|--------------------------------------|
| <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: _____