MEDICAL RELEASE FORM

Substitutions of this form will not be accepted

All applicants must have a medical examination within twelve months prior to date of Get Away applying for.

Applicant's Name _____ City _____ State _____

Date of Birth _____/_____/_____ Height _____ft _____in Weight _____lbs Blood Pressure _____/_____

Medical diagnosis of disability _____

_____

Explanation/Onset/Cause of disability _____

Applicant's current health condition _____

Activities applicant should not participate in _____

Operations/Serious Illness (include Dates & Description) _____

Chronic/Recurring Illness _____

Applicant has seizures ❒ No ❒ Yes - Frequency _____ Date of last seizure _____ Controlled by medication _____

Describe seizure _____

DISEASES/PAST ILLNESS

❒ Diabetes ❒ Asthma

❒ Chicken Pox ❒ Tuberculosis

❒ Other _____

ALLERGIES

❒ Penicillin ❒ Aspirin ❒ Latex ❒ Hay Fever

❒ Food _____

❒ Other _____

IMMUNIZATIONS *Enter month & year of each immunization*

❒ HEP A Date 1 _____ Date 2 _____

❒ HEP B Date 1 _____ Date 2 _____ Date 3 _____

❒ HIB Date 1 _____ Date 2 _____ Date 3 _____

❒ DPT/DT/TD Date 1 _____ Date 2 _____ Date 3 _____ Date 4 _____ Date 5 _____

❒ Polio/IPV Date 1 _____ Date 2 _____ Date 3 _____ Date 4 _____ Date 5 _____

❒ MMR/MMRV Date 1 _____ Date 2 _____ Date 3 _____ Date 4 _____ Date 5 _____

MEDICATION *Pre-packaged from Pharmacy accepted - Please list additional medications on separate page*

ALL MEDICATIONS MUST BE IN ORIGINAL PRESCRIPTION BOTTLE MARKED FOR CONTENT, DOSAGE, AND FREQUENCY

Medication Name	Dosage
Example: Dilantin chewable	*two 50mg tablets*

Adverse reactions from medications _____

PHYSICIAN PERMISSION

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in Special Touch Ministry Inc. functions through the end of the calendar year, except as noted above.

Physician's Name _____

Physician's Signature _____ Date _____

RN, LPN, QMRP signatures are NOT acceptable

Clinic Name _____ Phone _____

Address _____

City State Zip

MAIL COMPLETED APPLICATION TO: **Special Touch Ministry, Inc. - CPO, PO Box 25, Waupaca, WI 54981**

Fax to: 715-258-2777 or Email a PDF scanned copy of the application to: centralprocessing@specialtouch.org

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SAMPLE