



# PHYSICIAN'S PERMISSION FORM

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

**NO SUBSTITUTIONS OF THIS FORM**

Get Away Location \_\_\_\_\_

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

### ALLERGIES

- Diabetes
- Chicken Pox
- Other \_\_\_\_\_
- Asthma
- Tuberculosis

- Penicillin
- Food \_\_\_\_\_
- Other \_\_\_\_\_
- Aspirin
- Latex
- Hay Fever

### 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, otherwise all medications must be in original prescription bottle marked for content, dosage, and frequency - List additional medications separately**

Medication Name	Dosage
<i>Example: Dilantin chewable</i>	<i>two 50mg tablets</i>
_____	_____
_____	_____
_____	_____
_____	_____

Adverse reactions from medications \_\_\_\_\_

### PHYSICIAN PERMISSION

I have examined the person herein described and 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 \_\_\_\_\_

Immediately return the signed and completed Permission Form to one of the following options:

- Fax to (715) 258-2777 • Scan and Email to cpo@specialtouch.org. No JPEGs
- Mail to Special Touch Ministry, Central Processing, PO Box 25, Waupaca, WI 54981.