2027 PHYSICIAN'S PERMISSION FORM

NO SUBTITUTIONS OF THIS FORM

A medical exam is required within 12 months prior to the Get Away.

Get Away Location Applying for_____

Applicant's Legal Name _____ DOB ____/___/_____

Mailing Address: _____

Preferred Name (if different) _____ Gender at Birth ☐Female ☐Male

Height _____ft _____in Weight _____lbs Blood Pressure _____/_____

Medical diagnosis of disability _____

Explanation/Onset/Cause of disability _____

Current health condition _____

Activities applicant should **NOT** participate in _____

In the last five years list any major surgeries, serious illnesses, chronic conditions, or illnesses that have occurred. Also, list any prior condition **that currently affect the patient's ability to participate in a Summer Camp program** (regardless of the date of occurrence). _____

APPLICANT ☐ Has Diabetes: ☐ Controlled by _____ ☐ Has Asthma: ☐Uses Inhaler ☐ Uses Epi Pen (Epinephrine)

❒ Has Seizures: Controlled by _____ Frequency _____ Date of last seizure _____

ALLERGIES ☐ Check here if allergy list is attached (application will be incomplete if box is checked and separate list not attached)

❒ Penicillin ☐Aspirin ☐Latex ☐Medication (list)_____

❒ Food (list)_____

❒ Hay Fever ☐Seasonal/other (list) _____

MEDICATION (check one)

☐ Medication list is attached (application will be incomplete if box is checked and list not attached)

☐ Currently not taking any prescribed medications

Describe any adverse reactions from medications including specific conditions when contact should be made with the physician.

_____

_____

Medications brought to Get Away, including pharmacy packaged medication, MUST be properly labeled by pharmacy with name, content, dosage, frequency, route, prescribing physician, prescription number, and date prescribed. **The Medical Staff will only administer and assume responsibility for medications that are physically documented and submitted in this fully compliant format. We cannot be held responsible for prescribed medications known by the participant, parent, or guardian—or even documented on this form - if they are not formally submitted to our staff during the check-in process and properly labeled by the pharmacy as directed.**

PHYSICIAN PERMISSION *RN, LPM, QMRP signatures are NOT acceptable*

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 next 12 months, except as noted above.

Physician's Name (print/type)_____ **Phone** _____

Physician's Signature _____ **Date** _____

Clinic Name _____ Email _____

Address _____

Scan and Email completed form and ALL attachments to Central Processing:

cpo@specialtouch.org

Questions:

715-258-2713

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