



**Eagle Mount – Bozeman
Physician Approval**

Name _____ D.O.B. _____

Address _____ Phone _____

_____ Phone _____

I give permission for the exchange of professional information pertinent to My/my child's therapeutic program.

_____ Date _____
Signature of Individual or Parent Guardian

This portion to be completed by Physician:

Height _____ Weight _____ Sex: M F

Diagnosis _____

Date of Injury/Onset _____ Cause _____

Medications (Type, Purpose, Dose) _____

If Downs syndrome: Cervical X-Ray for Atlanto-Axial Subluxation:
Positive _____ Negative _____ X-Ray Date _____

Please indicate if the client has **any history** of the following medical conditions:

<u>Yes</u>	<u>No</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Defect/High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Shunt: Type/location _____
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Traumatic Brain Injury
<input type="checkbox"/>	<input type="checkbox"/>	Post Traumatic Stress Disorder Mild Moderate Severe

(Continued on Back)



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<u>Yes</u>	<u>No</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery or Serious Illness _____
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to bleed easily
<input type="checkbox"/>	<input type="checkbox"/>	Serious Bone or Joint Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric/Behavior Problems
		IQ below 75
<input type="checkbox"/>	<input type="checkbox"/>	Speech Defects
<input type="checkbox"/>	<input type="checkbox"/>	Auditory Defects _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid _____ Right _____ Left
<input type="checkbox"/>	<input type="checkbox"/>	Visual Defect in one or both eyes _____
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Eyeglasses
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke/Exhaustion
<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	Wears Braces: Type _____
<input type="checkbox"/>	<input type="checkbox"/>	Uses Wheelchair/Walker/Crutches/Cane
<input type="checkbox"/>	<input type="checkbox"/>	Spasticity or Rigidity
<input type="checkbox"/>	<input type="checkbox"/>	Issues with: Muscle Tone; Balance; Coordination
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Exercise-induced Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicine _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to foods _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to insect stings/bites _____
<input type="checkbox"/>	<input type="checkbox"/>	Dietary Restrictions _____
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations are up-to-date
<input type="checkbox"/>	<input type="checkbox"/>	Date of last tetanus shot _____/_____/_____

Medical Forms must be signed by physician.

To the best of my knowledge, the above information is true and correct.

TO MY KNOWLEDGE, THERE IS NO REASON WHY THIS PERSON CANNOT PARTICIPATE IN THE SUPERVISED RECREATIONAL ACTIVITIES OF SWIMMING, SKIING, HORSEBACK RIDING, ICE SKATING, KAYAKING, FISHING, HORTICULTURE, GOLF, CYCLING (unless noted below)

Restricted Program(s): _____

Comments: _____

Physician's Signature _____ Date _____

Printed Name _____ Phone _____

Address: _____

Please return this form to: Eagle Mount, 6901 Goldenstein Lane, Bozeman, MT
Phone: 406/586-1781 Fax: 406/586-5794