Eagle Mount Bozeman
Physician Approval

Name_____ D.O.B. _____

Address _____ Phone _____

_____ Phone _____

I give permission for the exchange of medical information pertinent to my/my child's therapeutic program. Further, I understand that this form must be updated **annually** and is valid for one year from the date of the physician's signature.

_____ Date _____
Signature of Individual or Parent/Guardian

This portion to be completed by Physician:

Height _____ Weight _____ Sex: _____

Diagnosis_____

_____

Date of Onset _____ Cause_____

Medications (Type, Purpose, Dose) _____

_____

_____

If Down syndrome: Cervical X-Ray for Atlanto-Axial Subluxation:
Positive _____ Negative _____ X-Ray Date _____
Mandatory annual physician's statement for neurological symptoms of AAI:
Yes ____ (please attach statement)

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

Yes	No	Condition
□	□	Heart Disease/Heart Defect/High Blood Pressure
□	□	Chest Pain or Fainting Spells
□	□	Seizures/Epilepsy
□	□	Diabetes
□	□	Head Injury
□	□	Shunt: Type/location _____
□	□	Concussion

(Continued on Back)

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PARTICIPANT LAST NAME: _____

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

10/12/2018