MEDICAL RELEASE FORM

FOR PARTICIPATION IN CAMP NORTHSTAR

PART 1 - PERSONAL INFORMATION:

NAME:	M/F	Date of Birth (month/date/year)	
Camper's/CIT Address			
City	State	Zip	Camper/CIT Home Phone #
Name of Parent / Guardian		Parents Phone No. (if different)	
Address (if different)		Parents Work No.	

PART 2 - HEALTH HISTORY

YES	NO		YES	NO	
		Heart disease / heart defect / high blood pressure			Allergy:
		Chest pain			Medicines: _____
		Seizures / epilepsy / fainting spells			Insect stings/bites: _____
		Diabetes			Special diet
		Concussion or serious head injury			Asthma
		Heat Stroke / exhaustion			Tobacco use
		Blindness / visual problem			Easy bleeding
		Contact Lenses / glasses			Emotional/psychiatric/behavioral
		Hearing loss / hearing aid			Sickle cell trait or disease
		Bone or joint problem			Immunizations up to date

OTHER _____

PART 3 - IMMUNIZATION

IMMUNIZATION	1ST DOSE	2ND DOSE	3RD DOSE	BOOSTER	IMMUNIZATION	1ST DOSE	2ND DOSE	3RD DOSE	BOOSTER
TETANUS/DIPTHERIA					DPT				
HEPATITIS B					HIB				
RUBELLA					POLIO				
CHICKEN POX					MUMPS				
TETANUS/DIPTHERIA					MEASLES				
INFLUENZA TYPE B					VARIVAX				

PART 4 - PHYSICAL EXAMINATION

Blood pressure: _____ / _____ Weight:_____ Height: _____

NORMAL	ABNORMAL		NORMAL	ABNORMAL	
		VISION			RESPIRATORY SYSTEM
		HEARING			GASTROINTESTINAL SYSTEM
		ORAL CAVITY			GENITOURINARY SYSTEM
		NECK			SKIN
		EXTREMITIES			CRANIAL NERVES
		CARDIOVASCULAR SYSTEM			COORDINATION
		REFLEXES			

Atlanto Axial instability Assessment for athletes with Down Syndrome

_____YES _____NO Has an x-ray evaluation for atlanto-axial instability been done? Date of exam _____/_____/_____

_____Yes _____NO If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

Primary MR Etiology / Category (if known): _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 monts and certify that the athlete can participate in Camp Northstar

RESTRICTIONS _____

EXAMINER'S SIGNATURE _____DATE _____/_____/_____

EXAMINER'S NAME:_____MD Liscence# _____

ADDRESS: _____

_____PHONE: _____