



Camp STIX participant – Physician’s Release

(To be completed by health care provider)

This form is **REQUIRED** for all campers and must be returned 

DOB: ____/____/____

Name of camper: _____

Notable Medical Problems: _____

Allergies (food or drug) and type(s) of reactions: _____

Specialty Diet or Food Preferences: _____

Medications (over the counter and prescription): _____

Date of last tetanus: _____ Date of MMR shot: _____ Are Immunizations current? YES / NO

Physical Examinations: Blood Pressure: _____ Weight: _____ Height: _____

Normal: (check) Abnormal: (describe below) Date of Exam (if different from completion date): _____

- | | | | |
|----------------------------------|--------------------------------|--|--------------------------------------|
| <input type="checkbox"/> General | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Head | <input type="checkbox"/> Mouth | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Extremities |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Neck | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Psych |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Heart | <input type="checkbox"/> Neurological | <input type="checkbox"/> _____ |

Notes about abnormalities: _____

May this individual actively participate in camp activities without limitations? [YES/NO] If no, please explain: _____

Diabetes Information (if applicable): Last Hemoglobin A1c: _____ Date: _____

Current diabetes regimen: Types of Insulin Used: _____ Type of Insulin Pump: _____

Any specific tasks or goals that this individual needs help with: _____

Other information for Medical Staff: _____

PLEASE NOTE: THIS IS A VERY ACTIVE 6 DAY CAMP. WE NEED TO KNOW OF ANY PHYSICAL, SOCIAL OR EMOTIONAL DIFFICULTIES WHICH COULD IMPEDE FULL PARTICIPATION.

Sign below if this individual is medically cleared to participate at Camp STIX. Date: _____

Provider’s Name/Title: _____ Provider’s Signature: _____

Provider’s Address: _____ Provider’s Phone: _____

Please upload your completed form to your CampDoc Camper Registration Portal.

For technical issues with your *Camper Registration Portal* please contact CampDoc at (734) 636-1000.

For questions about form content, email Camp STIX Medical Director at campstixmash@stixdiabetes.org