The Cassie Hines
SHOES CANCER
FOUNDATION

Medical Release Form

IMPORTANT:
Participant (or parent/legal guardian for participants under 18) should complete and sign the top section of this form, authorizing the release and transmission of medical information to The Cassie Hines Shoes Cancer Foundation ("CHSCF") for consideration of the Participant's Application.

I give permission for my physician to provide medical information directly to CHSCF.

Participant____Date____________________

I give permission for my son/daughter's physician(s) to provide medical information directly to CHSCF.

Parent/Legal Guardian____Date________________

Health Care Provider: The Cassie Hines Shoes Cancer Foundation's ("CHSCF") Sample Camp and similar camp programs include a variety of daily activities which may be challenging for some participants. Daily activities for most camp programs may include and are not limited to: physically challenging training, high intensity aerobic activity, hiking, and extended periods of walking. Dietary and climate changes also add to the physical intensity of the camps, as well as the probability of a change in sleep schedules. Please be considerate of these factors as you evaluate the Participant's physical readiness for such conditions.

To Be Completed by Participant's Health Care Provider

Physician's Name (*please print*) ____

Address____

City____ State______________ Zip_________

Phone (________) ______________________

Participant's Name________________________________ D/O/B__________________

Type of Diagnosis_______________________________ Date of Diagnosis____________

Has the Participant completed treatment? Y_____________ N____________

If yes, date of last treatment ____

If no, in the month prior to camp, what type of treatment will he/she be receiving?

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Are the Participant's immunizations up to date? Y______N______If no, please explain. _____

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Describe any special condition(s) or care needed by the Participant while at camp or during airline travel:

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Describe any physical disabilities, limitations, or restrictions:

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Is the Participant cleared for airline travel? Y______N______

I have reviewed the Participant's **medical information and history**. I have performed a physical exam and (p*lease indicate the appropriate choice below*):

□ I find the Participant to be in adequate condition for travel and participation in the aforementioned daily activities, except for those physical limitations and restrictions listed above.

□ I have prescribed a medical plan of action for the Participant to meet prior to participating in the camp program in order to participate in the daily itinerary during the camp.

□ I do not recommend the Participant participate at this time.

Physician's Signature________________________________ Date_____________________

Please return to: CHSCF, PO Box 345, Washington, Michigan 48084
Fax: (586) 232-1273 / Email: camp@cassiehinesshoescancer.org