The Cassie Hines
SHOES CANCER
FOUNDATION

Travel Medical Release Form

Release of medial information to CHSCF for air travel:

Participant (or parent/legal guardian for participants under 18) should complete and sign below, authorizing the release and transmission of medical information to The Cassie Hines Shoes Cancer Foundation (CHSCF)for consideration of the participant's application for air travel.

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

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

Parent/Legal Guardian_____Date_____

To Be Completed by Participant's Health Care Provider

Physician's Name (*please print*)_____

Address_____

City_____ State_____ Zip_____

Office Phone_____

Participant's Name_____ D/O/B_____

Original cancer diagnosis:_____

Date of original Diagnosis_____

Has the Participant completed treatment? Y_____ N_____

Is the participant vaccinated for COVID-19 Y_____N_____ If no, and the reason is medical please explain.

_____

_____

Describe any special care needed by the participant during airline travel.

_____

_____

_____

_____

Describe any physical disabilities, limitations, or restrictions the airline should be aware of.

_____

_____

_____

_____

Is the participant cleared by their oncology team for airline travel? Y_____N_____

Please return to: CHSCF, PO Box 345, Washington, Michigan 48094
Fax: (586) 232-1273 / Email: camp@CHSCF.org