DISABILITY SERVICES RESOURCE CENTER
-Serving People With Disabilities Since 1933-

Medical Release/Health Examination Form

MEDICAL RELEASE (to be completed by **Legal Guardian**)

Participant's Name _____ Date of Birth _____

If the participant will need medication while in our care, provide, for each medication, its name, dosage amount, and dispensing time(s) _____

_____

_____

Participant's known allergies _____

_____

Does, or should, the participant have any limitations on physical activity? ○ YES ○ NO

Does the participant wear hearing aids, glasses, contact lenses, or other devices? ○ YES ○ NO

Has the participant ever lost consciousness during physical activity? ○ YES ○ NO

Does the participant have any seizure disorders? ○ YES ○ NO

If the answer to any of the questions above is YES, please specify _____

_____

I, (Legal Guardian, please print) _____, **consent to the participation of the above-named participant in Disability Services Resource Center's**

☐ Summer Special Needs Enrichment Program ☐ ACES Softball ☐ Wheelers & Dealers Bowling ☐ Other _____ _____

I also agree to emergency medical treatment, if deemed necessary.

_____ _____

Legal Guardian's Signature Date

HEALTH EXAMINATION (to be completed by **Physician** prior to start of program)

Participant's Name _____ Date of Birth _____

Height _____ Weight _____ B/P _____ Pulse _____

Abnormal Physical Findings _____

_____

Recommendations/Limitations _____

_____

Physician's Name (please print) _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

_____ _____

Physician's Signature Date