



Physician Approval

**Return as soon as possible to: Eagle Mount, 2822 3rd Ave. No. Ste. 203, Billings, MT 59101
(406) 245-5422 Fax (406) 245-4390**

This form necessary every three years

Please indicate all programs that participant is interested in, if known:

Programs: Swim ___ Ski ___ Golf ___ Biking ___ Arts & Crafts ___ Camp ___
Equestrian ___

Name of Participant: _____ Date of birth _____

Address _____ Phone _____

I give permission for the exchange of medical information pertinent to my /my child's involvement.

Parent/Guardian _____ Date _____

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The following Medical History to be completed by the physician:

Disability Diagnoses/Date of onset: _____

Height _____ Weight _____

Allergies (medicines) _____

Surgeries _____

Illnesses, including seizures _____

Injuries _____

Deficiencies present in: _____ Mobility _____ Coordination
_____ Neuro-Sensation _____ Muscle tone _____ Balance
_____ Sight _____ Hearing _____ Speech

Are braces or other assistive devices used? _____ Yes _____ No If yes, please list.

Ambulatory ___ Yes ___ No Incontinence ___ Yes ___ No

Circulatory Problems ___ Yes ___ No Respiratory Problems ___ Yes ___ No

Comments: _____

If the diagnosis is **Down Syndrome**, please provide results of diagnostic X-ray for Atlantoaxial Dislocation Condition: Date & Results _____

Is the patient currently receiving prescribed therapy or treatment? ___ Yes ___ No

From whom: _____

Except as noted, I am unaware of apparent contraindications to participation, under appropriate supervision, in the above Eagle Mount activities.

X _____ Date _____

Physician's Signature