DOCTOR RELEASE

Dear Doctor,

The child that you are seeing for a health screen has applied to attend our youth Summer Camp. United American Indian Involvement, Inc. utilizes Summer Camp to provide health screens and assure that there are no existing health concerns that would limit the youth's participation and/or to coordinate access to necessary care, if so determined. The PHN (Public Health Nursing) Staff for UAII conduct a health assessment similar to a school physical. The assessment also includes an eye exam to see if they need further evaluation for glasses and if the BMI calculation comes out to be greater than 24, we conduct a random blood glucose with a finger stick or if there is family history of diabetes, a hemoglobin A1C also with a finger stick to determine possible follow up for diabetes. Also included in the assessment is a head lice screening.

The Summer Camp will be held July 25-30, 2022 in Big Pine, CA, where there will be physical activities including hiking and climbing. We are asking for your verification of "no limitations" and release to participate in camp activities.

Patient Name_____ Today's Date_____Male_____Female_____

Age_____Date of Birth_____Height_____Weight_____Blood Pressure_____

Primary Doctor_____ Phone #_____ Address_____

The patient is taking the following medication(s): _____

The patient has partial health limitations and **may** participate in the following activities:

_____Archery	_____Hiking	_____Volleyball	_____Softball
_____Basebal	_____Horseback Riding	_____Climbing	_____Swimming
_____Dancing	_____Bicycling	_____Running	_____Basketball

❑ Immunizations are up to date, tetanus booster date:_____

❑ If camper has **NOT** been fully immunized, "I understand and accept the risks to my child from not being fully immunized."

_____

Special restrictions, recommendations and/or comments (attached additional information if needed):_____

_____

_____

_____

I have read through this camper's Health History Form and have discussed the camp program with the camper's parents/guardians.

_____ _____ _____

Doctor's Name (print) Doctor's Signature Date