

**PHYSICIAN PERMISSION
For Participation In the 2018
CAMP SPIRIT
EB WINTER ADVENTURE CAMP**

Date _____

NAME _____ **BIRTHDATE** _____

ADDRESS _____

CITY _____ **ZIP** _____

FATHER / MOTHER _____

DIAGNOSIS _____

COMMENT (INCLUDE PRECAUTIONS)

I give my permission for the above named patient to participate in Camp Spirit, The RDEB Winter Adventure Camp.

Physician's Signature _____

Dear Doctor:

Would you please complete and sign the Children's Hospital Colorado Permission Form and either fax it to the number below, or give to the child's parents to return with their camp application.

Thank you,

Kaycie Artus
Director, Camp Spirit
2429 Bitterroot Lane
Golden, CO 80401

Phone: (303) 526-1018
FAX (303) 526-4102