# PHYSICIAN PERMISSION
# For Participation In the 2019
# CAMP SPIRIT
# EB WINTER ADVENTURE CAMP

**Date** ______________________________

**NAME** __________________________________ **BIRTHDATE** ____________________

**ADDRESS** __________________________________________________________________

**CITY** ________________________________ **ZIP** _______________________

**FATHER / MOTHER** ____________________________________________________________

**DIAGNOSIS** ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**COMMENT (INCLUDE PRECAUTIONS)**

________________________________________________________________________________

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________________________________________________________________________________

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 this Permission Form and fax it to the number below.
Thank you,

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

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