

MEDICAL EVALUATION

To be completed by a Licensed Healthcare Practitioner

Required for any participant diagnosed with cancer

If the participant has had a medical evaluation within the prior 12 months by a licensed health care practitioner, you may attach a copy in lieu of this medical evaluation. The evaluation must include the practitioner's signature and date. A recent examination within the past 6 months is required of any participant who is currently under medical care, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from head injury.

Name _____ DOB ___/___/___ Age _____

NOTE TO LICENSED HEALTH CARE PRACTITIONERS: *Your patient will be attending a whitewater adventure program for a week that includes hiking, rafting, camping and vigorous group activities. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations - attach additional sheets as needed.***

PHYSICAL EXAMINATION: *(to be completed by a licensed health-care practitioner)*

Height _____ Weight _____ BP _____/_____ Pulse _____ Body Mass Index _____

Oncology Diagnosis: _____ Diagnosis date: _____

Other Medical Conditions/Diagnosis: _____

Medication *(dose, route, frequency)*: _____

Does this patient use medical equipment daily that requires electricity? _____

Please be advised: no electricity is available for the week your patient is attending the program!

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

URINALYSIS: *(when indicated)* Albumin _____ Sugar _____

Check Box:	Norm	Abn		Norm	Abn		Norm	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Integument	<input type="checkbox"/>	<input type="checkbox"/>

Explain any abnormal finding: _____

Use of an assistive device: Brace Splint Prosthetic Cane Crutch

Approved for all activities? *(hiking, camping, whitewater rafting, and vigorous sports)* Yes _____ No _____

List Restrictions (if any): _____

Allergies: _____

Diet restrictions _____

Healthcare Professional Name *(print)* _____

Phone _____

Signature _____ **M.D./D.O./N.P/PA-C Date** _____

Address _____

City, State, Zip _____

To be completed by your Licensed Healthcare Practitioner



Medical Release for Angel Flight Program Flight

Your patient, _____, has requested assistance with transportation for his/her medical needs. In order for this to occur, please print your name and sign the following to confirm that this patient may safely fly in a small non-pressurized aircraft. If you have any questions, please call us at: (310) 390-2958. Thanks for your cooperation in assisting this patient.

_____, is medically stable and able to fly in a non-pressurized small aircraft.

In addition, I confirm that the patient does not have any medical/psychiatric conditions that could affect the safety of the flight.

Such conditions could be (but are not limited to): seizures, psychiatric conditions, and/or conditions that require the use of medical equipment in flight.

The cabin of a small aircraft can be smaller than the inside of a vehicle. Please be sure that any condition would not interfere with the ability of the pilot to fly the aircraft. This would include physical interference, or the emotional interference that something such as a seizure could cause.

Print Physician Name: _____

Physician Signature: _____

Physician Phone #: _____ **Email:** _____ **Date:** _____

EMAIL or MAIL TO:
River Discovery
P.O. Box 8336,
Boise, ID 83707
riverdiscovery@gmail.com

Angel Flight West

Phone: (310) 390-2958 www.angelflightwest.org

Please do not send this directly to Angel Flight! Please return to your patient or to the program facility requesting this document. They will return all participants' releases at one time to us.