



## Maine Handicapped Skiing PHYSICIAN STATEMENT

(Please Print Clearly)

The following form **MUST** be completed by a licensed physician.

Patient's Name:		Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Height:	FT	IN	Weight: LBS
<b>PATIENT NAME</b>		is able to participate in Maine Handicapped Skiing's Adaptive sports programming. This may include activities such as alpine skiing, cross country skiing, snowshoeing, snowboarding, cycling, golf, canoeing, and kayaking.	
What is the nature of this person's disability?:			
Please List any medications:			
How may these medications effect his/her participation?			
Does this patient have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the following questions regarding their seizures:			
What type of seizure?	When was their last seizure?	Is the patient on medication for seizure activity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please Check one of the following:</b>			
<input type="checkbox"/> I recommend participation without limitation.			
<input type="checkbox"/> I recommend participation with the following limitations/suggestions:			
<input type="checkbox"/> I do not recommend participation.			
<b>PHYSICIAN NAME (PRINTED):</b>			
<b>ADDRESS:</b>			
<b>TELEPHONE:</b>		<b>FAX:</b>	
<b>PHYSICIAN SIGNATURE</b>		<b>DATE:</b>	
<b>8 Sundance Lane, Newry, ME 04261</b>		<b>207-824-2440(phone)</b>	
Date Received: / /		<a href="mailto:schedule@skimhs.org">schedule@skimhs.org</a> (email)	
		<b>207-824-0453(fax)</b>	
		2009/2010	

