

Partners In Adventure

Inclusive Camps, Social / Recreational Opportunities for people with disabilities and friends



Partners In Adventure Health Form

Please have the following filled out by a physician:

Participant's Name: _____

Known Health

Issues/Problems/Allergies: _____

To my knowledge there is no reason why this person cannot participate in supervised camp activities, including horseback riding, swimming, boating, downhill skiing, snowboarding, ice fishing, etc. Suggested adaptations for activities include:

Restrictions: _____

Physician's name:(please print) _____

Physician's signature: _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date _____