# JOSHUA'S CAMP CORPORATION



## (EE-1) JOSHUA'S CAMP MEDICAL ASSESSMENT AND CLEARANCE

Child/Patient Name: _____ Birthdate _____

Address_____ City _____ State _____ Zip _____

Name And Specialty Of Physician Completing Form:

Name (please print) _____ Specialty _____

Hospital/Clinic Affiliation _____

Contact Address _____

Phone _____ Fax _____ Email _____

Best time and preferred method of contact _____

Child's Diagnosis _____ Date of Diagnosis _____

Is child currently undergoing treatment? No _____ Yes _____ please explain

(treatment type, duration, *phase of treatment,* estimated end date, not currently under treatment)

_____

_____

_____

---

List any special recommendations or limitations _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____