

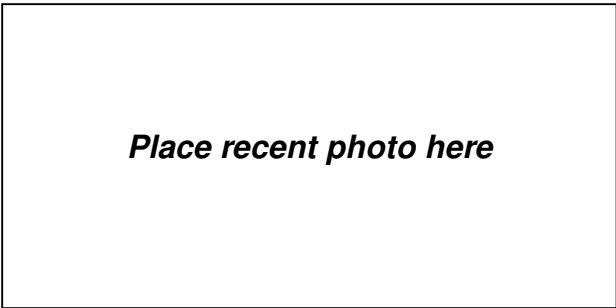
Applicant Name: \_\_\_\_\_

**MUSCULAR DYSTROPHY ASSOCIATION**  
**2011 SUMMER CAMP VOLUNTEER MEDICAL STAFF APPLICATION**

Instructions: Thank you for your interest in volunteering for MDA's summer camp program. Quality volunteer medical team members are critical to the Association's goal of providing safe and fun-filled activities for youngsters with neuromuscular disease. **PLEASE BE SURE TO WRITE CLEARLY IN BLACK OR BLUE INK ONLY.** Please be sure the information provided in the application is correct and complete. Any false statement or misrepresentation of the facts called for on this application or any unsatisfactory reference check will be cause for rejection of your application or your immediate dismissal from camp at MDA's sole discretion.

Completion of this application does not guarantee a volunteer position at MDA Summer Camp. Acceptance is contingent upon evaluation of this application by the MDA Camp Director, MDA medical advisors and other MDA risk-management personnel. All information you provide on this form will be used by MDA's Camp Director to advise appropriate camp staff and volunteers only when deemed necessary. MDA reserves the right to deny admission to camp or dismiss a volunteer whose physical condition, mental condition, behavior, personal conduct, or influence on other camp participants is deemed detrimental to the camp community. **IF THIS APPLICATION IS NOT COMPLETED, YOU WILL BE REFUSED ADMISSION TO CAMP.**

A recent **color photograph** of the applicant should be included with this application. This photo will assist camp staff in identifying volunteers for medications and in ensuring the safety and security of all participants. While the photo need **not** be a passport photo, it should be a **recent color** photograph of the applicant's face. This photo should be pasted below.



**A PRE-CAMP MEDICAL HEALTH EXAMINATION IS REQUIRED FOR ALL VOLUNTEERS** (pages 11-12). This section should be completed by the physician who usually and most frequently cares for the applicant *and should not be a member of the applicant's family*. The volunteer must be evaluated by such physician or medical professional in the twelve months just prior to the camp session or at any time prior to the camp as may be required by MDA.

**SECTION ONE \*\*\* Medical Staff Profile**

**Complete in black or blue ink only.**

Name: \_\_\_\_\_  
(Last) (First) (Middle) (Nickname/other surname if any)

Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (County) (State) (Zip)

How long at this address? \_\_\_\_\_

Previous Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (County) (State) (Zip)

How long at this address? \_\_\_\_\_

Please identify all states lived in as an adult: \_\_\_\_\_

Telephone #: ( ) ( ) ( )  
(Home) (Work) (Cell Phone)

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Applicant Name: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Alternate Email Address \_\_\_\_\_  
Languages Spoken: English  Spanish  Other  (Please list): \_\_\_\_\_

Professional Degree: MD  DO  PA  NP  BSN  RN  LPN  PT  OT  RT  OTHER

Are you licensed to practice in your profession in the state where the MDA camp session for which you are applying is located? (CHOOSE ONE) YES NO

Licensure in State: \_\_\_\_\_ **(Please attach a copy of license)**  
(Name all states applicable)

Date Issued: \_\_\_\_\_ License #: \_\_\_\_\_

Fed. Narcotics #: \_\_\_\_\_ State Narcotics #: \_\_\_\_\_

Medical Malpractice Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Please attach certificate of medical malpractice insurance (if applicable)**

### **PROFESSIONAL EXPERIENCE**

You may attach additional sheets, if necessary, to provide more details when answering the following:

Have you attended MDA Summer Camp before? (CHOOSE ONE)  YES  NO

If yes, please indicate below each city where you have volunteered for MDA camp, and specify the years at each location (use separate sheet if necessary):

<u>City</u>	<u>State</u>	<u>Years</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please explain briefly why you want to be a volunteer at MDA summer camp.

\_\_\_\_\_

What experience have you had with individuals with neuromuscular diseases?

\_\_\_\_\_

What experience have you had with health care for children?

\_\_\_\_\_

***You may elect to attach a copy of your current C.V. in lieu of answering the following questions in this section.***

Applicant Name: \_\_\_\_\_

**EDUCATION** (Attach additional sheets to provide more information if necessary):

Name of college/medical school/internship/residency	City & State	Program Description	Years attended - Date of degree granted

Please list your **PREVIOUS PRACTICE AND EMPLOYMENT EXPERIENCE FOR THE LAST EIGHT YEARS.** Please include the institution(s), city, state and dates. (you may elect to attach a copy of your current c.v.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following.**

Has your license to practice medicine, nursing, or health care in any jurisdiction ever been suspended or revoked? YES  NO   
(CHOOSE ONE)

Have your privileges at any hospital ever been suspended, reduced or not renewed? YES  NO   
(CHOOSE ONE)

Have you ever been denied membership, or renewal thereof, or been subject to disciplinary proceedings in any professional health-care related organization? YES  NO   
(CHOOSE ONE)

Have you ever had a claim against you alleging medical malpractice? YES  NO   
(CHOOSE ONE)

**If you answer "YES" to any of the above questions, please explain details below or on a separate sheet if more space is needed.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL STAFF REFERENCES AND CRIMINAL BACKGROUND CHECKS**

**REFERENCES:**

Applicants must provide three references of medical professionals who can speak authoritatively regarding your professional qualifications and personal attributes. MDA **will** contact references so please be sure the person(s) named has agreed to serve as a reference.

**Professional References: (Please PRINT)**

1. Name: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Years Known: \_\_\_\_\_  
(Street)

Applicant Name: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip) Phone: (\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_

2. Name: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Years Known: \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip) Phone: (\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_

3. Name: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Years Known: \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip) Phone: (\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_

**CRIMINAL BACKGROUND CHECKS:**

- Have you ever been arrested for a felony, misdemeanor, traffic violation or driving under the influence of illegal drugs or alcohol?  YES  NO (CHOOSE ONE)
- Have you ever been charged for a felony, misdemeanor, traffic violation or driving under the influence of illegal drugs or alcohol?  YES  NO (CHOOSE ONE)
- Have you ever been convicted of a felony, misdemeanor, traffic violation or driving under the influence of illegal drugs or alcohol?  YES  NO (CHOOSE ONE)

If yes to any of the above questions, please explain and give dates of the occurrence and disposition of the criminal charges. (A "yes" answer will not automatically exclude you from consideration.): \_\_\_\_\_

Do you consent to and authorize MDA to conduct a criminal background investigation?  YES  NO  
(CHOOSE ONE)

Social Security # (required): \_\_\_\_\_  
Driver's license # (if applicable): \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Maiden or other surnames (if applicable): \_\_\_\_\_  
Other than by marriage, has your first or last name changed? If so, please list all previous names: \_\_\_\_\_

1.) Have you ever been arrested, charged or convicted of any crime relating in any manner to  YES  NO  
children and/or your conduct with them? (CHOOSE ONE)  
If yes, please explain (Use a separate sheet if necessary.): \_\_\_\_\_

2.) Have you ever been arrested, charged or convicted of any crime including, but not limited to,  YES  
 NO the following?  
(CHOOSE ONE)  
*Assault and battery/ kidnapping/ distribution and trafficking of narcotics or other  
controlled substances/crimes of indecency/ sexual related crimes/ guns or weapons crimes.*  
If yes, please explain (Use a separate sheet if necessary.): \_\_\_\_\_

3.) Have you ever been adjudicated liable for civil penalties or damages involving sexual or physical abuse or  
been subject to any court order involving sexual or physical abuse of a minor, including, but not limited to a  
domestic order of protection? If yes, please explain (Use a separate sheet if necessary.):  YES  NO  
(CHOOSE ONE)

Applicant Name: \_\_\_\_\_

4.) (If applicable) Have your parental rights ever been terminated for reasons involving sexual or physical abuse of children or for any other reason?  YES  NO (CHOOSE ONE)  
If yes, please explain (Use a separate sheet if necessary.): \_\_\_\_\_

I understand that:

- a. MDA may deny volunteer opportunities to any applicant who answers any of the questions numbered 1-4 above in the affirmative or who answers any question falsely.
- b. In applying for a camp position the information which I have furnished on this form is subject to verification, which may include a criminal history check and request from any Central Registry of child abusers.
- c. MDA may deny volunteer service of any applicant for any reason in the best interests of the children at MDA's sole discretion.
- d. This disclosure statement is subject to review by all MDA staff with a need to know.
- e. I may be questioned further by MDA staff or other personnel associated with camp on any answer I provide at MDA's sole discretion.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

**SECTION TWO \*\*\* Medical Staff Health/Medical Information**

Please complete all requested information in the sections below. Please include any additional health information that is not specifically requested in the space at the end of this section. To the extent any information is designated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA), MDA agrees to abide by all applicable laws.

Name of your primary care physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

**MEDICAL INSURANCE COVERAGE**

***Attach photocopy of  
FRONT of  
insurance card***

***Attach photocopy of  
BACK of  
insurance card***

**Immunization Status:**

An up-to-date immunization status is required to attend camp. Please list the dates of your **most recent** immunizations and **attach a copy of immunization record**.

Mumps..... _____	German Measles (Rubella) .. _____
Td (Tetanus)..... _____	TOPV or OPV or Salk (Polio) _____
Measles (Rubeola) ..... _____	Flu/H1N1 ..... _____

Have you had H1N1? (CHOOSE ONE) YES NO **OR** UNKNOWN

**Immunization Documentation: (CHOOSE ONE)**

Copy of current official documented immunization record attached

Applicant Name: \_\_\_\_\_

- Religious Beliefs exemption form (if applicable by state law) signed by parent/guardian attached
- Medical exemption form signed by a physician and parent/guardian attached
- Signed Laboratory Proof of Immunity form attached

\_\_\_\_\_  
Signature of Applicant or Medical Professional

\_\_\_\_\_  
Date

1. Please list any **MEDICATION ALLERGIES** you have experienced: \_\_\_\_\_

2. Please list any **FOOD ALLERGIES** you have experienced: \_\_\_\_\_

3. **\*Other Allergies (e.g. sun, latex, plants, etc.)\*\*** \_\_\_\_\_

\*\*Since some campers may be accompanied by service animals, please indicate your typical reaction to and severity of any animal allergies so that appropriate accommodations can be made.

Do you have a history of any of the following illnesses or conditions; or are you receiving medications for such illnesses or conditions?

Anxiety/Depression	YES	NO	Hepatitis/Hepatitis Exposure	YES	NO
Asthma	YES	NO	Homesickness	YES	NO
Back/Neck Pain	YES	NO	Indigestion	YES	NO
Bee Sting Reactions*	YES	NO	Panic Attacks	YES	NO
Bladder Control Problems	YES	NO	Peanut/Nut Allergy*	YES	NO
Constipation	YES	NO	Pet Allergy*	YES	NO
Diabetes	YES	NO	Pneumonia	YES	NO
Diarrhea	YES	NO	Seizures/Convulsions	YES	NO
Ear Infections	YES	NO	Severe Menstrual Cramps	YES	NO
Eating Disorder	YES	NO	Shortness of Breath	YES	NO
Emotional Problems/Self Injurious Behavior	YES	NO	Sinusitis	YES	NO
Frequent Colds	YES	NO	"Swimmer's" Ear	YES	NO
Hayfever	YES	NO	Urinary Tract Infections	YES	NO
Headaches	YES	NO	Wheezing	YES	NO
Heart Conditions/Problems	YES	NO			

\*If you indicated any allergies above, will you be bringing an EpiPen to camp with you?  
(CHOOSE ONE) YES  NO

If you answered "yes" to any of the above illnesses/conditions listed above, please explain in detail: \_\_\_\_\_

Are you currently being seen (or been seen in the last 3 years) by a psychiatrist, psychologist, therapist or any other related specialist for any acute or chronic condition? (CHOOSE ONE) YES NO

If yes, list diagnosis and treatment plan: \_\_\_\_\_

If you responded "yes" to the previous question, may MDA contact this person if the MDA Camp Director or medical staff feels it is necessary and in your best interest or in the best interest of the camp community?  
(CHOOSE ONE) YES  NO

Name of Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to applicant (i.e. physician, psychiatrist, etc.): \_\_\_\_\_

Cell/pager: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Applicant Name: \_\_\_\_\_  
 Do you have any medical, mental or emotional conditions which may affect your ability to perform any of the essential functions of MDA camp medical staff? (CHOOSE ONE) YES  NO

If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_

Are you physically able to lift and care for campers? (CHOOSE ONE) YES  NO

If no, please explain \_\_\_\_\_

Please provide any medical information that is pertinent to your application and which the MDA Camp Director and medical staff should be aware of: (special diet, pregnancy, motion sickness, recent surgeries, serious injuries, depression, suicide threats or attempts, eating disorder, anxiety disorder, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been exposed to a communicable disease (e.g. head lice, strep throat, mononucleosis, etc.) in the last six (6) months? (CHOOSE ONE) YES  NO  If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Please notify the MDA office if you have been exposed to a communicable disease after submission of this application.

### MEDICATIONS

Please list **ALL** prescription medications (such as antibiotics, birth control pills, asthma medications, insulin, "heart pills", anxiety disorder medications) and **all** non-prescription medications (such as allergy pills, cold tablets, vitamins, antacids) which you are personally bringing with you to camp. **PLEASE BRING ALL PRESCRIPTION MEDICATIONS IN THE ORIGINAL CONTAINER(S) WITH THE ORIGINAL PHARMACY LABEL(S) OR ASK YOUR PHARMACIST FOR AN EXTRA, FULLY-LABELED CONTAINER FOR USE AT CAMP. BE SURE TO BRING ENOUGH OF YOUR MEDICATIONS FOR THE FULL WEEK CAMP STAY, PLUS TWO (2) ADDITIONAL DAYS.**

Medication Name	Dose	Reason for Medication	Time Doses Are Given
Medication Name	Dose	Reason for Medication	Time Doses Are Given
Medication Name	Dose	Reason for Medication	Time Doses Are Given
Medication Name	Dose	Reason for Medication	Time Doses Are Given

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

## SECTION THREE \*\*\* Legal Releases—Guidelines and Agreements PLEASE COMPLETE AND SIGN ALL PARTS OF EACH SUB-SECTION

### MEDICAL CONSENT AND EMERGENCY CONTACTS

#### MEDICAL CONSENT

The health information contained in this application is correct so far as I know and I have permission to engage in all prescribed camp activities, except as noted by me and/or an examining physician. I certify to the best of my knowledge, I do not have any contagious or communicable disease or condition. I also understand that MDA and the camp are not responsible for illness due to previous injuries, health conditions or illness incidental to attending camp.

If there should be an emergency while I am at the MDA Summer Camp or going to and from camp, I authorize treatment by the MDA Summer Camp medical staff. The MDA Summer Camp medical staff maintain a medical cabin on the camp grounds. They are able to evaluate and treat most minor illnesses and injuries as well as stabilize any serious medical conditions. I also authorize routine treatment by the MDA Summer Camp medical staff during the week of camp. I authorize the MDA Camp Director or medical staff of the camp to select and designate emergency medical personnel, nurses, physicians, and/or surgeons to



Applicant Name: \_\_\_\_\_  
arising out of or resulting from any and all injuries or damages of any nature, including death, which I may suffer while taking part in MDA

Summer Camp or any activities connected with the MDA Summer Camp. **I UNDERSTAND THAT THIS MEANS THAT I AGREE NOT TO SUE any or all of the Released Parties in connection with the event.** I further understand that I assume all risks in participating in MDA Summer Camp. I further recognize that MDA cannot be held responsible for loss of clothing or personal property while at camp, and I will try to have all belongings plainly marked. In addition, I understand that some camp counselors or volunteers may be under age eighteen. I also acknowledge that any activity in which I may choose to participate with MDA campers or volunteers after the close of camp session is at my own risk.

This release shall be binding upon me, my heirs, executors, administrators and assigns.

I acknowledge that MDA's Camp program typically may include but is not limited to the following activities:

Archery    Boating    Horseback Riding    Motorcycle sidecar or    3-wheel cycle rides    Swimming

In addition, the following special activities may be included in the camp program

Canoeing, Water Fight, Dances, Children's Rides, Fishing, Hay/Wagon/Train Rides, Arts & Crafts, Video Game Playing, Wheelchair Races, Rock Wall Climbing, Obstacle Courses, Cooking, Eating, Wheelchair Soccer, Petting Zoos, Karaoke, Card/Board Games, Playing With Various Toys, Campfires, Makeovers, Travel to alternate venues such as (but not limited to) Camp Tracey, Hollywood Connection, Tracy Aviary, Parks, Movies, Etc.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

### **MDA Summer Camp Policies**

Please read the following MDA Summer Camp Practices and Policies Agreement CAREFULLY and THOUGHTFULLY, then sign the statement of compliance that follows.

**RESPECT:** Each camp participant -- including campers, counselors, cabin leaders, activity staff, medical staff and administrative staff -- has a responsibility to respect the camp leadership, as well as the health and well-being of the MDA camp community. Personal information about campers received during orientation or the camp session must be held in strictest confidence. Each camp participant is expected to be a considerate cabin mate and be respectful to people and their belongings. Profanity is not allowed and hazing and initiations are not permitted.

**MEDICAL SERVICES:** Every camp participant must turn in a completed medical status form prior to camp. The camp will provide medical care to anyone who becomes ill or injured during the camp session. All treatment and/or healthcare will be administered by authorized and licensed medical team members. Medication (prescription and over-the-counter) must be kept in the infirmary and dispensed by medical staff. The medical staff must be advised promptly of any injuries, allergies or health problems.

**CELL PHONES:** Camp medical staff must abide by cell phone policies as stated by MDA Camp Director. Campers, volunteers and other program staff are not permitted to have cell phones at MDA Summer Camp. Exceptions are frequently made for camp medical staff.

**DRESS CODE:** Females should wear one piece bathing suits only. Please do not wear "short shorts," low cut tanks, or shirts with inappropriate slogans. Shirts promoting liquor or with sexual references are not appropriate at camp. Please wear closed toe shoes at all times. No flip-flops.

**MORAL BEHAVIOR:** Everyone at camp is expected to behave in a morally upstanding way. Public displays of affection between campers and/or volunteers/medical staff is not tolerated. Obscene, pornographic or lewd materials are not allowed. Any sexual activity at camp is strictly forbidden.

**CURFEW:** Everyone is urged to get enough sleep to be able to function effectively throughout the day. All campers and volunteers are expected to return to and remain in their sleeping quarters with lights out by the

Applicant Name: \_\_\_\_\_  
curfew established by MDA's Camp Director. These curfews will be strictly enforced and breaking curfew will result in the camp participant's immediate dismissal from camp.

**CAMPGROUNDS:** MDA leases facilities to host local summer camp sessions. The camp's facilities and equipment should be treated with the utmost care and respect. All camp participants should take care not to damage or destroy any camp property and to be considerate of all wildlife on the campgrounds.

**ACTIVITY SCHEDULE:** Camp participants are expected to take part in the daily camp program by following the camp schedule and attending activities.

**TIME OFF:** Each volunteer is entitled to a daily break as scheduled by the MDA Camp Director. Camp participants may not leave the campgrounds without written approval from the MDA Camp Director.

**TRAVEL-IN-THREE'S SYSTEM:** All campers must be accompanied by at least 2 volunteers at all times. Always practice the "rule of three" during the camp week.

**VISITORS:** Visitor's Day is primarily for MDA sponsors and key volunteers. No other visiting is permitted, including parents of campers, during the camp week.

**VALUABLES AND CASH:** Everyone is urged not to bring valued clothing, accessories, computer or camera equipment. MDA and the camp are not responsible for loss or damage to personal property. For individuals who drive themselves to the campsite, you are required to turn your keys over to the MDA Camp Director for safe keeping until departure day.

**SMOKING:** All participants must abide by the smoking policies established by the MDA Camp Director and camp facility.

**ALCOHOL, DRUGS AND WEAPONS ARE FORBIDDEN:** The possession or use of alcoholic beverages and the possession or use of illegal drugs are strictly forbidden and will be grounds for immediate dismissal from camp. The possession of any weapon (firearm, knife, explosives, etc.) is strictly forbidden on camp property as well. The weapon will be confiscated and the participant will be dismissed from camp.

In order to attend the MDA Summer Camp, I will adhere to the rules set forth here and those established before and during the camp session:

1. I will respect the camp leadership and the entire camp community.
2. I understand that the paramount interest at MDA Summer Camp is the safety and best interests of the campers and that my main objective is to help provide a positive and safe experience for those youngsters in attendance.
3. I will serve as medical staff for the MDA Summer Camp in a professional and courteous manner.

I have read the above Practices and Policies and agree to abide by the policies detailed in this contract, as well as those established by the MDA Camp Director and his/her designated camp assistants. I am fully aware that adhering to the above and any camp facility rules will be my sole responsibility. Deviation from these policies and rules may be cause for immediate dismissal from the Camp and I will have to make arrangements for transportation at my sole expense.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Applicant Name: \_\_\_\_\_

**MEDICAL STATUS: TO BE COMPLETED BY PHYSICIAN**

(Physician/Health Professional should not be a member of applicant's family)

**This section is to be completed by the volunteer's primary care physician, or other primary medical professional and is used to determine if the volunteer is eligible to attend MDA's summer camp program.** This evaluation must take place in the twelve months just prior to the camp session.

Medical Applicant's Name: \_\_\_\_\_

Vital Signs: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_  
Resp. Rate (resting): \_\_\_\_\_ Blood Pressure (Resting, Sitting): \_\_\_\_\_

General Inspection: \_\_\_\_\_

STATUS, ESSENTIAL FINDINGS, DEVIATING FROM NORMAL

Head .....	
Eyes/Vision .....	
Nose .....	
Mouth/Teeth .....	
Ears/Hearing .....	
Neck/Thyroid .....	
Thorax/Lungs .....	
Heart .....	
Abdomen/Hernia .....	
Skin .....	
Lymphatics .....	
Spine .....	
Extremities .....	
Emotional Status .....	

**NOTE TO HEALTH PROVIDER:**

Applicant Name: \_\_\_\_\_

1. The above named person wishes to participate as a volunteer at the Muscular Dystrophy Association Summer Camp. Participation involves group living and activities in an outdoor setting, a high level of physical activity, swimming, and attending to the needs of individuals with serious and often life-threatening neuromuscular diseases. At a limited number of camps, participants may be exposed to high altitude. **In your medical opinion, is MDA camp an appropriate environment for this individual?** (CHOOSE ONE) YES NO

2. I have examined the person herein described and have reviewed his/her health history. **Is it your opinion that the applicant is medically, physically and emotionally able to participate as a volunteer at the MDA Summer Camp, which includes a high level of physical activity -- including lifting and caring for individuals affected by a neuromuscular disorder?** (CHOOSE ONE) YES NO

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

**A PHYSICIAN/HEALTH PROFESSIONAL MUST SIGN IN THE SPACE PROVIDED BELOW:**  
\*Physician/Health Professional should not be a member of participant's family.



Physician/Medical Professional's Name (Please Print)	Address
Physician/Medical Professional's Signature	City State Zip
Date	( ) Phone #