

**EAGLE MOUNT
MEDICAL REPORT**

Dear medical provider: The following individual has joined Eagle Mount. In order to participate in our programs, we need the participant's medical provider to complete, sign & return this form by fax or mail. Eagle Mount provides therapeutic & recreational activities for adults & children (ages 6 weeks & up) with disabilities. Eagle Mount, P.O. Box 2866, Great Falls, MT 59403 | Phone: (406) 454-1449 | Fax: (406) 454-1780

Participant's Name _____ Birth Date _____

Parent / Guardian Name _____ Home Phone _____

■ Diagnosis: _____

■ Date of Last Physical Exam: _____ Weight: _____ Height: _____

■ SEIZURES: Is this person subject to seizures? ___yes, ___no; if yes, date of last seizure: _____
Describe the seizure: Type: _____ How frequent? _____
Seizure triggers: _____ How long do the seizures last? _____

■ DOWN SYNDROME: For Down's please indicate Atlantoaxial Dislocation condition and date of last x-ray: _____

■ **This participant is able to participate in active therapeutic recreational program activities for and with people with disabilities appropriate to his or her age and abilities.

_____ Full Participation _____ Limited Participation _____ No Participation

Some activities we provide are: Mounted Horseback Riding, Non-mounted Horsemanship Activities, Alpine Skiing / Snowboarding, Ice Skating, Sled Hockey, Karate, Bowling, Gymnastics, Tippy Toes (Creative Movement & Dance for infants and toddlers), Float trips on Rafts, Pontoon Rides, Fishing, Summer Fun Days (variety of day time activities), Friday Night Out (movies, games and dance night), Senior Activities. Please note that all activities are adapted to the needs our participants - adaptive equipment, safety equipment and trained staff and/or volunteer assistance is utilized at all times.

LIMITATIONS OR RESTRICTIONS ON RECREATIONAL / PHYSICAL ACTIVITIES:

MEDICAL CONCERNS/TREATMENT TO BE MONITORED DURING ACTIVITIES:

■ PROVIDER SIGNATURE: _____ Date: _____

Provider's Name/Title (printed): _____

Address: _____ Phone Number: _____