

**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

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Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_

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■ 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

LIMITATIONS OR RESTRICTIONS ON RECREATIONAL ACTIVITIES:

MEDICAL CONCERNS/TREATMENT TO BE MONITORED DURING ACTIVITIES:

■ PROVIDER SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Name/Title (printed): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_