Maine Adaptive
SPORTS & RECREATION

PHYSICIAN STATEMENT

(Please Print Clearly)
The following form MUST be completed by a licensed physician.

Patient's Name:	Date of Birth:	Sex: ❑ M ❑ F
Height: FT IN	Weight: LBS	
What is the nature of this person's disability?:		
Please List any medications:		
How may these medications affect their participation?:		
Does this patient have seizures? ❑ Yes ❑ No If yes, please answer the following questions regarding their seizures:		
What type of seizure?	When was their last seizure?	Is the patient on medication for seizure activity? ❑ Yes ❑ No

Maine Adaptive's sports programming may include activities such as alpine skiing, cross country skiing, snowshoeing, snowboarding, cycling, golf, paddling, tennis and fishing.

PLEASE CHECK ONE OF THE FOLLOWING:

❑ I recommend participation without limitation.

❑ I recommend participation with the following limitations/suggestions:

❑ I do not recommend participation.

PHYSICIAN NAME (PRINTED):	
ADDRESS:	
TELEPHONE:	**FAX:**
PHYSICIAN SIGNATURE:	**DATE:**

PO Box 853, Bethel, ME 04217 **207-824-2440**(phone) **207-824-0453**(fax)
(or save a copy and email that to info@maineadaptive.org)

Date Received: / /