



PO Box 948, Walworth, WI 53184
262.275.5753 www.InspirationMinistries.org

Health Certificate/Physician's Orders Form

The health care of every participant shall be under the supervision of a physician. The physician shall, prior to admission, certify that the participant has been examined within the last 24 months (90 days for residential applications). For the safety of your patient, please print and complete each line.

Name: _____ Date of Birth: _____

Date of Physical Exam: _____

Height: _____ Weight: _____ BP: _____

Date of last TB skin test or chest x-ray: _____ Date of last Tetanus shot: _____

I verify that the above-named participant is free from apparent communicable disease, including tuberculosis, that is detrimental to other participants.

Medical Diagnosis: _____

Significant past Medical History (include onset): _____

Past behavioral concerns: _____

Current treatment(s) at the time of this report include: _____

MEDICATIONS (check here if attaching a POS ; please have Physician sign and date)

Drug _____ Drug _____

Dose/Schedule _____ Dose/Schedule _____

Diagnosis _____ Diagnosis _____

Drug _____ Drug _____

Dose/Schedule _____ Dose/Schedule _____

Diagnosis _____ Diagnosis _____

VITAMINS / OTHER

AMBULATION

Participant may ambulate with appropriate assistive device and assist as needed.

Yes No Weight bearing status: Full As tolerated None

Describe any limitation or restriction on activities: _____

DIET

Regular Special (specify) _____

Any medically prescribed meal plan or dietary restrictions: _____

ALLERGIES

Drug Other _____ No Known Allergies

List allergy(ies) and describe reaction(s): _____

THE FOLLOWING PRNs MAY BE GIVEN:

_____ for pain _____ for fever

_____ for indigestion _____ for nausea

_____ for cough _____ for skin irritation

_____ for constipation _____ for diarrhea

Antihistamine Decongestant Other _____

RECOMMENDATIONS, LIMITATIONS, CONTRAINDICATIONS:

I give my permission for the above-named participant to engage in Inspiration Ministries programs.

Physician Signature: _____ Date: _____

Physician Name (please print or type): _____

Address, City, State, Zip: _____

Phone: (_____) _____ Fax: (_____) _____

PLEASE RETURN TO:

(for Residential, Flexible Respite Care)
(for Summer/Respite Camps)

Inspiration Ministries, Attn: Michelle Lussmyer
Inspiration Ministries Camp and Retreat Center, Attn: Kristi Logterman
P.O. Box 948
Walworth, WI 53184-0948
Phone: 262.275.6131 Fax: 262.275.3355