The Cassie Hines SHOES CANCER FOUNDATION

Medical Release Form

IMPORTANT:

Participant (or parent/legal guardian for participants under 18) should complete and sign the top section of this form, authorizing the release and transmission of medical information to The Cassie Hines Shoes Cancer Foundation ("CHSCF") for consideration of the Participant's Application.

I give permission for my physician to provide medical information directly to CHSCF.

Participant_____Date_____

I give permission for my son/daughter's physician(s) to provide medical information directly to CHSCF.

Parent/Legal Guardian_____Date_____

To Be Completed by Participant's Health Care Provider

Physician's Name (*please print*) _____

Address_____

City_____ State_____ Zip_____

Phone (_____) _____

Participant's Name_____ D/O/B_____

Type of Diagnosis_____ Date of Diagnosis_____

Describe any special condition(s) or care needed by the participant for airline travel:

_____

_____

_____

_____

Describe any physical disabilities, limitations, or restrictions the airline should be aware of:

_____

_____

_____

_____

Is the Participant cleared for airline travel? Y_____N_____

Please return to: Karen Hines:khines@chscf.org or fax to 586-232-1273