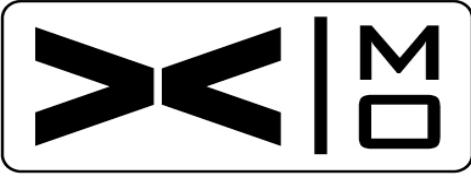


**Extreme Mobility Camps, Inc.**  
**3578 Claridge Court**  
**Simi Valley, CA 93063**  
**805-501-7231**  
[xmocamps@gmail.com](mailto:xmocamps@gmail.com)

## **PHYSICIAN'S REPORT**

### **RESTRICTION:**

Extreme Mobility Camps, Inc. is not staffed to care for participants with mental and/or physical problems whose care requires medically licensed staff and/or maximum supervision by an adult. Participants must be able to walk on their own and independently care for their personal needs. Those with multiple disabilities may not be eligible. Persons with enuresis or encopresis should not attend xmogames. Participants must be able to perform daily hygiene activities (dress, comb hair, shower, etc.), and personal activities (eating, restroom, etc.) unassisted.



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**Name:** \_\_\_\_\_

PHYSICIAN'S REPORT: (to be completed by physician)

ARE ALL IMMUNIZATIONS CURRENT? \_\_\_\_\_

DATE OF LAST TETANUS VACCINE? \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

MEDICATIONS (please include type/dosage/purpose):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RESTRICTIONS (if any): \_\_\_\_\_

\_\_\_\_\_

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE ARE PHYSICALLY ABLE TO ENGAGE IN XMOGAME ACTIVITIES (downhill skiing, cross-country skiing, etc.).

SIGNATURE: \_\_\_\_\_

LICENSED PRIMARY CARE MEDICAL PROFESSIONAL

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

PRINT

ADDRESS: \_\_\_\_\_

NUMBER & STREET

CITY

STATE

ZIP

PHONE: \_\_\_\_\_ DATE: \_\_\_\_\_