Montana Association for the Blind
1302 24th St. W.

PMB 134

Billings, MT 59102

406-442-9411

2025 SUMMER ORIENTATION PROGRAM for the Blind and Partially Sighted

Mail completed form to:

MAB
1302 24th St. W.
PMB 134
Billings, MT 59102
Or email to: mabadmin@mabsop.org

Part 2 – Physical Examination Report – To be completed by your Physician.

PLEASE TYPE OR PRINT CLEARLY

Name:

_____

CLIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

My medical information may be released to the Montana Association for the Blind's 2025 Summer Orientation Program staff, nurses, and director.

Client Signature:

_____

Date Signed:

_____ **Date of last**

PLEASE TYPE OR PRINT CLEARLY

physical exam: _____
Note: exam must be within 6 months of June 2025

Physical Examination:

Height: _____ Weight: _____

Pulse Rate: _____ Blood Pressure: _____

Excluding the client's visual problem can the client walk approximately 4 blocks without assistance, including gentle slopes?
Yes _____ No _____

Does the client walk with the aid of a walker or mobility support? Yes _____ No _____

Does the client have a hearing loss? Yes ____ No _____

If yes which ear? _____

Does the client have a heart condition? Yes _____ No _____

Does it cause physical limitations? Yes _____ No _____

If yes, please explain:

_____

_____

_____

_____

PLEASE TYPE OR PRINT CLEARLY

Does the client have any allergies? Yes _____ No _____

What are they: _____

Explain fully:
_____

_____
___

Does the client have: (Please check if yes)

Arthritis _____
Asthma _____
Incontinence _____
Mental Disorders _____
Dementia _____
IBS or and IBS-type syndrome _____

Diabetes _____ Controlled by: Insulin _____
Oral Preparation ____ Both _____ Diet only _____

The patient will be attending a 4-week long training program to learn independent living skills. Classes will run from 8 am to 4 pm. There will be some walking and standing involved. We will have a nurse or CNA on duty part-time to assist with basic medical needs. The student will be living and sharing bathrooms with other people. Are there any other physical concerns we should be aware of? Yes No
Please explain
_____

PLEASE TYPE OR PRINT CLEARLY

_____

_____ Please explain any medical conditions that we should be aware of. Attach another page if necessary.

_____

_____

_____

Does the client have any physical limitations excluding their vision?
Yes _____ No _____

If yes, please explain:

_____

_____

_____

Condensed medical history/diagnostic findings:

_____

_____

_____

_____

PLEASE TYPE OR PRINT CLEARLY

List all medications prescribed and used by client: (Attach another page if necessary)

_____

_____

_____

_____

Signature of examining physician:
_____Date:
_____

Print or type name:
_____
____

Address:
_____

Phone Number: _____

Primary medical doctor with his address and phone number:

_____

_____

_____

If you, as the prospective student's doctor, have any questions or concerns about our program, please contact us. Our phone number is: 406-442-9411