



The Cassie Hines
**SHOES CANCER
FOUNDATION**

Travel Medical Release Form

Release of medial information to CHSCF for air travel:

Participant (or parent/legal guardian for participants under 18) should complete and sign below, authorizing the release and transmission of medical information to The Cassie Hines Shoes Cancer Foundation (CHSCF) for consideration of the participant's application for air travel.

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

Participant _____ DOB _____

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 _____

Office Phone _____

Participant's Name _____ D/O/B _____

Original cancer diagnosis: _____

Date of original diagnosis _____

Has the Participant completed treatment? Y _____ N _____

Describe any special care needed by the participant during airline travel.

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

Is the participant cleared by their oncology team for airline travel? Y _____ N _____

Please return to:

Fax: (586) 232-1273 / Email: camp@CHSCF.org