



MONTANA ASSOCIATION FOR THE BLIND

1302 24th St W, PMB 134
Billings, MT 59102
406-442-9411

2026 SUMMER ORIENTATION PROGRAM for the Blind and Partially Sighted

If this form is not accessible, [CLICK HERE](#)

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 staff, nurses, and director for the
2026 Summer Orientation Program.**

Client Signature:

Date Signed: _____

PLEASE TYPE OR PRINT CLEARLY

Date of last physical exam: _____

Note: exam must be within 6 months of June 2026

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 use a walker or other 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 attend a 4-week training program to learn independent living skills. Classes will run from 8 am to 4:30 pm. There will be some walking and standing involved. We will have a nurse or CNA 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:

**List all medications prescribed and used by the 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 get in touch with us. Our phone number is: 406-442-9411