PHYSICIAN REFERRAL (REMISIÓN MÉDICA**) – please print clearly**

Physician Name _____

Patient Name _____ Date of Birth _____

Date Last Seen _____

Current Medications _____

_____

"Normal" Peak Flow Rate _____

Asthma is: _____ Mild Intermittent _____ Mild Persistent

_____ Moderate Persistent _____ Severe Persistent

Primary Allergies _____

Other Significant Medical Conditions _____

_____

Although Camp Wheez is medically supervised, your patient will continue to be under your direct medical care.

I would like the above-named patient to be enrolled in Camp Wheez. All breathing and exercise training is to be geared to the patient's capabilities.

_____ _____

Physician Signature Date

_____ _____

Physician Name (print) Phone

_____

Address, City, State, Zip Code

All forms are due by July 14, 2025. Email completed forms to campwheez@sansumclinic.org or mail to Sansum Clinic Allergy, PO BOX 1200, Santa Barbara, CA 93102-1200. Call with any questions or to confirm your form has been received: (805) 681-7635.

Ver. 04/2025