

Guide Dogs of the Desert  
P.O. Box 1692, Palm Springs, CA. 92263  
Phone: 760-329-1282 Fax: 760-329-2127  
Email: [admissions@gddca.org](mailto:admissions@gddca.org)

**INFORMATION RELEASE FORM**

I, \_\_\_\_\_, hereby give my consent and authorization to release information from the physicians, agencies and guide dog schools listed in my application, for the purposes of determining eligibility for a guide dog training program, to assist in providing appropriate medical attention, and for any other legal purpose deemed necessary by Guide Dogs of the Desert.

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Applicant Signature

Date

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Please print name

**A copy of this form will be sent to each physician, agency, and guide dog school.**

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**PHYSICIAN'S REPORT**

**Applicant:** This form must be completed by your primary physician upon an examination.

**Physician:** Your patient has applied for a guide dog to enhance his/her mobility and independence. When completing this form, Please keep in mind that the applicant will undergo rigorous training, both physical and mental. They will spend 28 days training and will be expected to walk a minimum of ½ hour twice daily in all types of terrain, with their guide dog regardless of weather conditions. Your information will help us provide your patient with the training and instruction most suited to their needs. The Ophthalmologist's report and verification of blindness is a separate form. Thank you for your assistance.

\*\*\*\*\*

Applicant's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Medical/Clinic ID number: \_\_\_\_\_

\*\*\*\*\*

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations \_\_\_\_\_

How long have you attended the applicant? First visit \_\_\_\_\_; # of years \_\_\_\_\_ Date of last tetanus immunization: \_\_\_\_\_

**Is applicant legally blind?**  Yes  No **Cause of blindness:** \_\_\_\_\_

**Does the applicant have any of the following medical problems?** (please answer yes or no)

Arthritis _____	Allergies _____	Asthma _____
Cancer _____	Circulatory Problems _____	Back Problems _____
Amputations _____	Addictions _____	High Blood Pressure _____
Seizures _____	Heart Disorder _____	Knee/Hip _____
Psychiatric Problems _____	Epilepsy _____	Intestinal Problems _____
Ulcers _____	Headaches _____	Foot Trouble _____
Infectious Diseases _____	Fainting _____	Neuropathy _____
Dexterity Problems _____	Nervousness _____	Speech Impairments _____

If yes, please explain \_\_\_\_\_

**Please list any surgeries** \_\_\_\_\_

**Does the applicant have a hearing problem?** \_\_\_\_\_ **Which ear?**  left  Right  Both

Does applicant wear hearing aides? \_\_\_\_\_ Is hearing within normal range with aides? \_\_\_\_\_

**Does applicant have a learning disorder?** \_\_\_\_\_

**Does applicant have any impairments of the use of either leg/foot?** \_\_\_\_\_ **Hand/arm** \_\_\_\_\_

**Is applicant diabetic?** \_\_\_\_\_ **If yes, please complete diabetic report.**

\* **Is applicant stable enough to undergo the rigors of training away from home for 28 days?** \_\_\_\_\_

**Date of exam on which report is based:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's signature**

Doctor's name: \_\_\_\_\_  
Please print

**HOSPITAL/CLINIC STAMP**

Telephone: (\_\_\_\_) \_\_\_\_\_

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**DIABETIC REPORT**

**Physician and applicant:** Guide Dogs of the Desert does not have a nurse on staff. Applicant must be capable of administering his/her own injections and must be responsible for maintaining an appropriate lifestyle. Diabetic meals are available. Our protocol is to call 911, should the applicant need assistance.

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Applicant's name: \_\_\_\_\_

Is Applicant :  Type 1    Type II    Stable    Brittle

Last Insulin reaction: \_\_\_\_\_ please describe: \_\_\_\_\_

Are Insulin reactions frequent? \_\_\_\_\_

Are Insulin reactions severe? \_\_\_\_\_

What can be offered in the event of a reaction? \_\_\_\_\_

Date of last hospitalization due to: Hypoglycemia \_\_\_\_\_      Hyperglycemia \_\_\_\_\_

Diet: \_\_\_\_\_

Oral Medication: \_\_\_\_\_      Daily Dosage \_\_\_\_\_

Insulin Name: \_\_\_\_\_      Daily Dosage \_\_\_\_\_

Does Applicant utilize an Insulin pump?  Yes    No

If yes please list any special instructions \_\_\_\_\_

Can Applicant self-administer Insulin? \_\_\_\_\_      Can Applicant adjust his/her own Insulin? \_\_\_\_\_

Please indicate any special instructions or suggestions \_\_\_\_\_

**I understand the protocol of Guide Dogs of the Desert and certify that the above information is true and correct.**

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Please print name

Date \_\_\_\_\_

Date \_\_\_\_\_

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**MEDICATION AND HEALTH INSURANCE INFORMATION**

**Physician and Applicant:** Please list all medications, strength, dosage, and reason for use. Also, please indicate any side effects that may affect the applicant during their time in training. Applicant is responsible for administering his/her own medication. Please ensure applicant has enough medication for the entire 28-day class.

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**Applicant's name** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

Medication	Strength	Dosage	Reason	Side Effects

**Health Insurance Information**

Policy number: \_\_\_\_\_  
Policyholder's name: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Telephone number: \_\_\_\_\_