PARTICIPANTS MEDICAL HISTORY AND PHYSICIANS STATEMENT

Participants Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian: _____

Diagnosis: _____

Tetanus Shot: _____Yes _____No Date: _____ Height: _____ Weight: _____

Seizure Type: _____ Controlled: _____Yes _____No

Precautions: _____

Medications: _____

** For person's with Down syndrome
Negative cervical X-ray for Atlantoaxial Instability X-ray Date: _____
Negative for clinical symptoms of Atlantoaxial Instability

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please explain.

AREAS	YES	NO	COMMENTS	AREAS	YES	NO	COMMENTS
Cardiac				Learning Disability			
Circulatory				Mental Impairment			
Pulmonary				Psychological			
Neurological				Metabolic disorder			
Muscular				Seizures			
Orthopedic				Asthma			
Visual				Diabetes			
Auditory				Bone/Muscle/Joint Condition			
Speech				Other			

Mobility: Independent ambulation: _____Yes _____No Orthotics/prosthesis: _____Yes _____No
Ear Health: Tympanotomy Tubes: _____Yes _____No Chronic Ear Infection: _____Yes _____No

To my knowledge there is no reason why this person cannot participate in a supervised therapeutic recreation program that may include swimming, sports, physical games, equestrian activities, playground activities, bicycle riding, horticulture, gymnastics, and other active recreational therapy activities.

Physician Name (Please Print) _____

Physician Signature & Date _____