



Date of Examination: _____ Height: _____ Weight: _____ Blood Pressure: _____

Medical Identification Information

Medi-Cal # _____ Medi-Care # _____ HMO Name: _____
 HMO Number: _____ Hospital Name: _____ Hospital Phone # _____
 Hospital Address: _____

Medical Precautions

Please Indicate "Yes" or "No" For The Following Medical Conditions:

Asthma: _____ Diabetes: _____ Kidney Disease: _____ Frequent Colds: _____ Heart Disease: _____
 Frequent Headaches: _____ Menstrual Difficulties: _____ Fatigue: _____ Speech Problems: _____

Operations Performed In The last 12 Months: _____

Type of Seizure (If Any): _____ Date of Last Seizure: _____

Procedure For Handling Seizures: _____

Types of Allergies: _____ Communication Level: _____
 _____ Alternative Communication: _____
 _____ Speech Therapy Required? _____

Does this person currently see a psychologist, psychiatrist, or neurologist? _____ Reason: _____

Vaccinations/Inoculations (Dates Required)

TB Administration Date: _____ TB Type: _____ TB Result: _____ Date Read: _____
 Last Tetanus: _____ Last Small Pox: _____ Last Typhoid: _____ Last Diphtheria: _____
 Is this person a Hepatitis B Carrier? _____ Hepatitis B Vaccination Date: _____

Medications Routinely Taken

Is This Person Able To Self Administer Medications: _____

<u>Medications</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Maximum Time Without Reason for Medication</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Activities Limitations

Physical Limitations

Health Limitations

Able to participate in swimming programs? _____ Able to participate in adaptive PE programs? _____

_____ Name Of Physician (Please Print) _____ Physician's Signature

Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

