MEDICAL INFORMATION

This medical will be valid for three years from the date issued by the physician.

THIS SECTION IS TO BE COMPLETED BY A PHYSICIAN <u>ONLY!!</u>

Please return to: South East Consortium
740 W. Boston Post Road, Suite 301
Mamaroneck, New York 10543
Telephone (914) 698-5232
Fax (914) 698-7125

PARENT/GUARDIAN IS RESPONSIBLE FOR UPDATING MEDICAL INFORMATION ON A REGULAR BASIS. Participants cannot attend programs without an updated medical.

Name:_____, _____, _____
Last Name First Name Middle Name

Primary Diagnosis:_____ **Secondary Diagnosis:**_____

Down Syndrome	☐ **Yes**	☐ **No**	**Atlanto-Axial Instability by X-Ray Evaluation Results Date:_____ ☐ Positive ☐ Negative ☐No X-Ray Given**

HISTORY OF… (include comments at right for "YES" responses)	**CHECK ONE**		**COMMENTS/OTHER RESTRICTIONS**
Allergies (Food, Bee Stings, Etc.)	☐ **Yes**	☐ **No**	
Anxiety	☐ **Yes**	☐ **No**	
Asthma	☐ **Yes**	☐ **No**	
Bladder/Kidney Problems or Loss of Function in one Kidney	☐ **Yes**	☐ **No**	
Bleeding Problem	☐ **Yes**	☐ **No**	
Bone or Joint Problem	☐ **Yes**	☐ **No**	
Bruising	☐ **Yes**	☐ **No**	
Circulatory Problems	☐ **Yes**	☐ **No**	
Contact Lens/Glasses	☐ **Yes**	☐ **No**	
Depression	☐ **Yes**	☐ **No**	
Diabetes	☐ **Yes**	☐ **No**	
Emotional Problems	☐ **Yes**	☐ **No**	
Fainting Spells	☐ **Yes**	☐ **No**	
Head Injury/History of Concussion	☐ **Yes**	☐ **No**	
Hearing Aid/Hearing Problems	☐ **Yes**	☐ **No**	
Heart Problems	☐ **Yes**	☐ **No**	**Blood Pressure _____/_____**
Heart Illness	☐ **Yes**	☐ **No**	
Hernia or Absence of one Testicle	☐ **Yes**	☐ **No**	
Hepatitis TYPE:_____	☐ **Yes**	☐ **No**	
Hypoglycemia or Hyperglycemia	☐ **Yes**	☐ **No**	
Motor impairment Requiring Special Equip. (i.e., Wheelchair, Orthopedic Device)	☐ **Yes**	☐ **No**	
Recent Contagious Disease	☐ **Yes**	☐ **No**	
Seizures: Date of Onset: _____/_____/_____	☐ **Yes**	☐ **No**	**Frequency: Duration:**
Type:	☐ **Yes**	☐ **No**	**Time of Day:**
Special Diet Needs	☐ **Yes**	☐ **No**	
Vision Problems and/or vision less than 20/200 in One or Both Eyes	☐ **Yes**	☐ **No**	
Other	☐ **Yes**	☐ **No**	

HISTORY OF DISEASE(S):			**DATE OF ONSET:**
Chicken Pox	☐ **Yes**	☐ **No**	
Mumps	☐ **Yes**	☐ **No**	
Measles	☐ **Yes**	☐ **No**	
Pneumonia	☐ **Yes**	☐ **No**	
German Measles	☐ **Yes**	☐ **No**	
Rheumatic Fever	☐ **Yes**	☐ **No**	
Tuberculosis	☐ **Yes**	☐ **No**	

MEDICAL HISTORY

IMMUNIZATION RECORD
(Required By NY State Law)
Any participant born before 1/1/57 does not have to complete the immunization record # 3 – 6

Diptheria/Tetnus Toxoid (4 doses) dates: **(must be boostered every 10 years)**	**1)**	**2)**	**3)**	**4)**
Hepatitis B Vaccine (3 doses):	**1)**	**2)**	**3)**	**4)**
Oral PolioVaccine (3 or more doses) dates:	**1)**	**2)**	**3)**	**4)**
Live Measles Vaccine (2 doses) dates:	**1)**	**2)**	**3)**	**4)**
Live Rubella Vaccine (1 doses) date:	**1)**	**2)**	**3)**	**4)**
Live Mumps Vaccine (1 dose) date:				
Haempphilus Influenza type B (Hib) (1 dose) date:				
Varicella (chicken pox) (1 dose) date:				

Give Dates: _____ **Results of:** **TUBERCULIN TEST**_____
_____ **CHEST X-RAY:**_____
_____ **TETANUS:**_____

MEDICATION INFORMATION: MUST BE FILLED OUT COMPLETELY, EVEN IF PARTICIPANT DOES NOT TAKE MEDICATION AT PROGRAMS. (Please Initial in the box provided if adult (age 18 or over) participant may self-administer medication during program hours). Please contact SEC office for medication self-administration form.

Initial	Medication	Purpose	Dosage	Frequency	Time

ALLERGIES TO MEDICATION: ☐ **YES** ☐ **NO** **If yes, What?**_____
_____

If there is a change in any of this information, a new form must be completed.

MEDICAL RELEASE

South East Consortium provides community-based recreation for individuals with disabilities, with an emphasis on physical activities. If you feel any particular activity is contra-indicated for this individual, PLEASE CHECK ONLY THOSE ACTIVITIES IN WHICH THE PARTICIPANT MAY NOT PARTICIPATE.

☐ **Alpine Skiing**	☐ **Diving**	☐ **Golf**	☐ **Soccer**	☐ **Track & Field**
☐ **Basketball**	☐ **Equestrian**	☐ **Gymnastics**	☐ **Softball**	☐ **Volleyball**
☐ **Bowling**	☐ **Figure Skating**	☐ **Motor Activities**	☐ **Strength Training**	☐ **Other**
☐ **Cycling**	☐ **Fitness/Aerobics**	☐ **Nordic Skiing**	☐ **Swimming**	
☐ **Dance**	☐ **Floor Hockey**	☐ **Roller Skating**	☐ **Tennis**	

I, the undersigned have reviewed the above medical history and certify there is no medical evidence available to me which would preclude his/her participation in South East Consortium for Special Services Recreation Programs.

Doctor's Name: (Printed)_____

Doctor's Signature ***(must be signed in ink)***_____

Address:_____

_____**Zip:**_____

Telephone: (_____)_____**Date**:_____

Fax:: (_____)_____ **E-Mail:**_____

Update 2/28/2006