

****PLEASE ATTACH A CURRENT PICTURE****

Medical Evaluation

Date _____ Male: _____ Female: _____
 Height: _____ Weight: _____

Name _____ Date of Birth _____
 Address _____ Social Security # _____

Phone Number (____) _____
 Parents Phone Number (____) _____
 Parent/Guardian Email Address _____
 Insurance Company _____
 Policy Number _____
 Name of the Insured _____

Emergency Contact: (Please do not use Parent as an emergency contact)

Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
Relationship _____	Relationship _____

Please check if member has any of the following conditions:

	Yes	No		Yes	No
Down Syndrome	___	___	Non-Verbal Individual	___	___
Atlanto-axial Evaluation	___	___	Motor Impairment	___	___
Hearing Impairment	___	___	Fainting Spells	___	___
Blindness	___	___	Heat Illness	___	___
Hepatitis	___	___	Hernia/Kidney	___	___
Diabetes	___	___	Emotional Problems	___	___
High/Low Blood Pressure	___	___	Allergies	___	___
Dietary Restrictions	___	___	Asthma	___	___
Heart Problems	___	___	Other: _____		

Current Medications:

Medication Name:	Amount:	Time:	Reason:

On a trip the following over the counter medication may be given:

___ Aspirin ___ Tylenol ___ Ibuprofen ___ Pepto Bismal ___ Tums
 ___ No medication may be given

Immunizations:

Tetanus Shot? Yes _____ No _____ Date of last Tetanus Shot _____

Medical Certification:

I have reviewed the above health information and examined _____ and certify there is no medical evidence available to me which would preclude this member's participation.

Any restrictions _____

Physician's Name _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____

Physicians Signature _____ Date: _____

Doctor/Parent Comments and/or Special Behavior _____

Release

I _____ am at least 20 years old and have submitted the attached evaluation for participation in ADD. I represent that to the best of my knowledge and belief, I am physically and mentally able to participate in ADD activities. I also represent that a certified physician has reviewed the health information contained in my application and has certified this based on the examination and has found no medical evidence, which would preclude me from participating in ADD activities.

If during my participating in ADD activities, I should need emergency treatment, and I am not able to give consent or make my own arrangements for that treatment because of injuries. I authorize ADD to take whatever measures are necessary to protect my health and well being, including, if necessary, hospitalization.

I, the member stated above, have read this paper and fully understand the provisions of the release that I am signing.

Signature of Member _____ Date _____

I hereby certify that I have reviewed this release with the member whose signature appears above. I am satisfied based on the review that the Member understands this release and has agreed to terms stated within.

Name _____ Signature _____ Date _____
Relationship _____

Office use only:

Date Rec'd _____

The Association for Developmental Disabilities program is open to persons regardless of race, religion, color, gender, age, sexual orientation, national origin or physical abilities.

This medical form will be valid from July 1, 2006 to June 30, 2008

Seizure Activity Status

Member Name _____

This page was not filled out because the member does not have a history of seizures (initial and date) _____

Type of Seizure _____ Date of Last Seizure _____
Frequency _____ Length of Seizure _____

Describe usual characteristics of seizure:

Indicate if any of the following characterize the seizures:

A= always S= sometimes N= never

<input type="checkbox"/> Falls to the floor	<input type="checkbox"/> Loss of responsiveness	<input type="checkbox"/> Abnormal Eye Movement
<input type="checkbox"/> Clenched Jaw	<input type="checkbox"/> Frothy Saliva	<input type="checkbox"/> Noisy Breathing
<input type="checkbox"/> Lips Pale Color	<input type="checkbox"/> Lips Blue Color	<input type="checkbox"/> Rigidity of trunk, arms & leg
<input type="checkbox"/> Jerking Movements of arms & legs		<input type="checkbox"/> Difficult to arouse after seizure

Describe activities or external stimuli that appears to precipitates members seizure activity:

Describe specific actions that should be taken if the member has a seizure

Describe post seizure behavior _____

Please list all medications _____

Do you wish to have an ambulance called immediately in event the member has a seizure ____

If there is any evidence of respiratory distress or injury, or if the seizure lasts more than 5 minutes, an ambulance will automatically called.

Member's Physician _____ Phone _____

Neurologist _____ Phone _____