Redwood

MEDICAL EXAMINATION FORM

Good health is important and greatly influences progress in our programs: Therefore, it is necessary for each individual in our programs to have a medical examination upon admission, and once yearly every year thereafter.

IDENTIFYING INFORMATION (to be completed by the family)

Name: ______________________ Program: ______________________
Date of Birth: ______________________ Social Security Number: ______________________
Address: ______________________
Home Phone Number: ______________________ Parent/Guardian: ______________________
In Case of Emergency: ______________________ Phone: ______________________

PHYSICIAN'S REPORT (to be completely filled out by the physician)

PRIMARY DISABILITY: ______________________
SECONDARY DISABILITY (S): ______________________
Disability is: ( ) Stable ( ) Progressive ( ) Recurrent ( ) Acute
Height: ________ Weight: ________ Temp: ________ Pulse: ________ Blood: ________

Please check the following if normal: (If not, explain below)

( ) Sight ( ) Hearing ( ) Nose/Throat ( ) Cardiovascular ( ) Lungs
( ) Abdomen & G.I. ( ) Genito-Urinary ( ) Muculo-Skeletal ( ) Skin

DESCRIPTION OF ALL ABNORMALITIES: ______________________

Please check previous or existing conditions and/or disease:

( ) Allergies ( ) Seizures ( ) Diabetes
( ) Heart Disease ( ) Cervical Instability ( ) Back Injury

Please indicate other conditions we need to be aware of: ______________________

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Please fill out other side

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Tuberculin test: Date: ______________ Positive: ________________ Negative: _____________

If this individual has Down's Syndrome, fill out this section:

Has this person had a cervical x-ray to rule out atalantoal-axial dysfunction?	________	Yes	________	No
Do results indicate atalantoal-axial dysfunction?	________	Yes	________	No

PHYSICAL CAPACITIES

	Yes	No	Explain
Can participate in a full day program?	______	______	____________________
Can sit daily, with breaks for 6 hours?	______	______	____________________
Can stand, with breaks for 6 hours?	______	______	____________________
Use of stairs?	______	______	____________________
Ability to lift?	______	______	____________________
Dietary restrictions?	______	______	____________________
Requires medical attention during the day?	______	______	____________________
I certify that this individual is in need of long term care for the mentally retarded or developmentally disabled	______	______	____________________

Please indicate with a "y" or an "n" which activities this individual is allowed to participate in as it relates to physical exercise:

_______ low impact aerobics __________ walking ___________ group sports (basketball, soccer, bowling, etc.)

Please list specific exercise activities that this individual should not participate in: ____________________________

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PHYSICIAN'S SIGNATURE: ______________________________ DATE: ___________________________

OFFICE ADDRESS: ____

OFFICE PHONE NUMBER: ____

PARENT/GUARIAN SIGNATURE: _________________________ DATE: ___________________________

PLEASE RETURN THIS FORM TO REDWOOD AS SOON AS COMPLETED. (Original: Nurses/Copy: Main File)

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