Arc of Westchester - Recreation Department Medical Form

Name: _____ **DOB:** _____ **Age:** _____

Height: _____ **Weight:** _____

Diagnoses: _____

Allergies: _____ **Epi Pen or other treatment:** _____

Medication: YES / NO **If yes, please list medications:**

Name of Medication	Dosage	Frequency

Special medication precautions or instructions: _____

_____

Seizures: YES / NO **Date of Last Seizure:** _____ **Type of Seizure:** _____

Follow up care for seizure or seizure plan: _____

TB/PPD test date: _____ **Type of test used:** _____ **Result:** _____ (induration in mm)
Positive or Negative: _____
If positive PPD: Chest x-ray date: _____ **Results:** _____ **Lungs Clear: YES / NO**
(If positive, a chest x-ray must be within 2 years and a check up of the lungs must be done annually)

Diabetes Plan: Yes ☐ **No** ☐ **(if yes, please describe or attach)** _____

_____

Special diet/choking risk assessment? (if individual has a choking plan, please attach) _____

_____

Other diagnoses: **Speech** ☐ **Hearing** ☐ **Vision** ☐ **Psychiatric** ☐
Describe: _____

Physical/Ambulatory limitations/restrictions: _____

_____

Other medical concerns/notes: _____

_____

_____

The Arc Westchester
Recreation and Respite Programs

Over the Counter Medication Administration

Name: _____ **D.O.B:** _____

Medication	Administration
Tylenol 325 mg Take 2 Tabs PO Q4H	Headache, pain, temperature of 101 or higher or general discomfort
Sunscreen and Insect Repellent will be used as needed, unless otherwise noted	Physician's note: (only necessary if not approved)

Additional over the counter medications if applicable: (please list medication name, reason for administration and instructions for each). ** Parents must supply additional over the counter medications listed below **

_____

_____

_____

Topical Treatments:
1) Minor cuts, scratches and abrasions:
Cleanse area with saline at time of injury.
Apply antibiotic ointment and bandage BID, as needed.

2) Insect bites or poison ivy:
Apply calamine lotion as needed.

3) Sunburn:
Apply Aloe Vera gel as needed.

On (date) _____, I examined _____ (name). I reviewed the above information and find it to be accurate. This individual is medically able to participate in Arc of Westchester recreational programs for one year from the date below. This individual may take part in physical activities while participating in recreational programs, when staff deems such activities to be beneficial. If there are any exceptions to this, they will be clearly noted above

Physician's Signature: _____ **Date:** _____

Printed Name: _____ **Tel:** _____

Address: _____

_____