MUST BE REVIEWED, SIGNED & STAMPED BY DOCTOR/HEALTH CARE PROVIDER

New Participant Medical Form

INSTRUCTIONS: The New Participant Medical form must be completed and returned to The Arc Westchester before enrollment in service(s). **Part 1** of the form must be completed and signed by the applicant and their parent/guardian. **The applicant's physician must review and complete Part 2 of this form**. The applicant should return the completed form along with the other application materials.

PART 1: TO BE COMPLETED BY PARENT/GUARDIAN/APPLICANT

Applicant's Last Name: _____ MI: _____ First Name: _____

MEDICAL INFORMATION:

Primary Doctor: _____ **Telephone:** _____

Dentist: _____ **Telephone:** _____

Applicant's Primary Diagnoses: _____

Additional Diagnoses: _____

HEALTH HISTORY (Check – giving approximate dates where indicated)

Conditions:	**Allergies:**	**Diseases:** **Date:**
☐ Frequent ear infections	☐ Asthma	☐ Mononucleosis
☐ Heart Defect/Disease	☐ Hay Fever	☐ Chicken Pox
☐ Diabetes: ☐ Type I ☐ Type II	☐ Poison Ivy	☐ Measles
☐ Bleeding/Clotting disorder	☐ Insect Stings	☐ German Measles
☐ Seizure*	☐ Penicillin	☐ Mumps
☐ History of Anaphylaxis to_____ Epi-Pen: ☐ Yes ☐ No		

Seizures (if yes): Date of Last Seizure: _____ Type of Seizure: _____* *****attach Seizure Response Plan**

Please elaborate on conditions indicated above & list additional allergies the applicant has (including food):

Is the applicant self-aware of allergies? ☐ Yes ☐ No

Please list any past illnesses (contagious and non-contagious): _____

_____

Does he/she use any adaptive equipment (ex: cane, wheelchair)? ☐ Yes, ☐ No **History of falls:** ☐ Yes, ☐ No

If yes, please explain _____

Does he/she have any vision impairment? ☐ Yes, ☐ No **Are glasses/contacts needed?** ☐ Yes, ☐ No

Does he/she have any hearing impairment? ☐ Yes, ☐ No **Is a hearing aid used:** ☐ Yes, ☐ No

Has the applicant been hospitalized within the past 2-years? ☐ No ☐ Yes – *if yes, please describe using the chart below*

Hospital	**Length of Stay (days)**	**Reason**

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MEDICATION: Does the applicant take prescription or over-the-counter medication (OTC)? ☐ NO, ☐ YES

If yes, use the chart below to list ALL prescription and OTC medications

MEDICATION:	DOSAGE:	FREQUENCY:	REASON FOR TAKING:
1.			
2.			
3.			
4.			
5.			

Can the applicant self-administer medication? ☐ Yes ☐ No

Special Medication precautions or instructions: _____

_____

Over the Counter (OTC) Medication Administration (for applicable programs)

Medication	Administration	Topical Treatments:
Tylenol 325 mg Take 2 Tabs PO Q4H	Headache, pain, temperature of 101 or higher or general discomfort	1) **Minor cuts, scratches, and abrasions**: Cleanse area with saline at time of injury. Apply antibiotic ointment & bandaged BID, as needed. 2) **Insect Bites or poison ivy**: Apply calamine lotion as needed. 3) **Sunburn:** Apply Aloe Vera gel as needed
Sunscreen and insect repellent will be used as needed, unless otherwise noted	Physician's note: (Only necessary if not approved)	

Parents are responsible for providing OTC medications listed in the chart above

History of choking: ☐ Yes ☐ No **Special diet/restrictions:** ☐ Yes ☐ No

(If yes, describe or attach) _____

_____

ADDITIONAL MEDICAL INFORMATION: Please provide in the space below any additional information about the applicant's health that you think is important or that may affect the individual's ability to fully participate in services. Attach additional information if needed.

_____

_____

CONSENT FOR MEDICAL TREATMENT

I hereby authorize that all the above information is correct. I agree to notify The Arc Westchester program directors of any changes in the applicants physical or mental health between the dates of enrollment and the start of services through The Arc Westchester. I hereby consent and authorize the administration of all medical treatments advisable or necessary under the judgement of the accredited program staff, emergency room physicians or any other clinical physicians with the understanding that I will be notified as soon as possible.

Parent/Guardian Name (print):	Parent/Guardian Signature:	Date:
Applicant Name (print):	Applicant Signature:	Date:

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PART 2: TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN

Name of Applicant (Last, First, Middle)	Date of Birth:

To be completed and signed by the Health Care Provider ONLY:
The individual named above has had a complete history and physical exam on the following date: _____ _____ _____
(Exam must be within one year of enrollment) Month Day Year

D.O.B: _____ Age: _____ Gender: ☐ M ☐ F Weight:_____ Height:_____

TB/PPD Test Date: _____ _____Test type used: _____ Result: _____ (induration in mm)

Positive or Negative: _____

If positive PPD: Chest x-ray date: _____ Result: _____ Lungs clear: YES / NO
(IF positive, a chest x-ray must be within 2 years and a check of the lungs must be done annually)

Physical/Ambulatory Limitations or Restrictions: ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Other Medical Concerns/Notes:
_____
_____
_____

I certify that on _____, I examined _____.
(MM/DD/YYYY) (Print First and Last Name)

Based on my examination and the medical history furnished, I have found no reason to make it medically inadvisable for this individual to participate in The Arc Westchester's programs or services for one year from the date below. I attest that the information provided on pages one and two of this form is accurate. This individual may participate in physical activities while participating in recreational or other programs when staff deems such activities beneficial. If there are any exceptions to this, they will be clearly noted above.

SIGNATURE OF PHYSICIAN: _____ Date: _____

Physician Name (Please Print): _____

IMMUNIZATION HISTORY

Please provide us with a record of basic immunization and most recent booster doses for the individual listed above.