

Westchester ARC Recreation Department Medical Form

Consumer's Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Date of last tetanus: _____

Diagnosis: _____

Medicaid # _____ Medicare # _____

Medication: YES / NO. If yes, please list meds:

Name of Medication	Dosage	Potential Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Medication Precautions: _____

Injections: YES / NO Hepatitis carrier: YES / NO

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

Follow Up Care for Seizure: _____

Downs Syndrome: YES / NO AAS: NEG. / POS. If positive, specify restrictions: _____

**TB/PPD test date: _____ Type of test used: _____ Result: _____ (Redness/induration in millimeters)
Positive or Negative: _____**

If positive PPD: Chest x-ray date: _____ Results: _____ Lungs Clear: YES / NO

(TB/PPD test must be within one year, if positive a chest x-ray must be within 2 years and a check up of the lungs must be done annually)

Diabetic: YES / NO If yes, describe treatment: _____

Medication Allergies (also list reaction): _____

Other Allergies (food/seasonal/etc.- also list reaction): _____

Special diet: _____

Impairments: [] speech [] hearing [] vision Describe: _____

Physical/Ambulatory limitations: _____

Other medical concerns/notes: _____

On (date) _____, I examined (consumer's name) _____. I have reviewed the above information and find it to be accurate. This consumer is medically able to participate in Westchester ARC Recreational Programs for one year from the date below. This consumer 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 _____ Emergency Tel #: _____