



**Participant Medical Information**

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian - Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please provide alternate contact information, in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Disability Diagnosis: \_\_\_\_\_ Hospitalizations within the past year: \_\_\_\_\_

If communication is limited, please explain how we can best communicate with this individual. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Mobility & Assistance:**

- Walks independently
- Manual Wheelchair
- Cane or Blind Care
- Electric Wheelchair
- Crutches or Walker
- Limited Walking/Standing

**Current Health Conditions:**

- Seizures within Last Year
- Penicillin / Latex / Other
- High Blood Pressure
- Frequent Nosebleed
- Allergic To Bee Stings
- Heart Problems
- Asthma / Respiratory
- Back Problems
- Sensitive to Sun
- Food Allergies
- Disorientation / Memory Problems
- Diabetes

**Personal Care Assistance:**

- Toileting
- Eating

Explanation of conditions above – attach additional pages if needed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If the ability to learn is limited, please explain which teaching methods work best for this individual (i.e. visual, verbal, tactile, etc.). \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What adverse behavioral conditions does the individual exhibit and how can we best address these situations? (i.e. hitting, spitting, biting, flight risk, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current medications/reason prescribed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medication side effects: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Positive Reinforcements: (i.e. verbal cues, favorite music, sports team, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Participant or parent/guardian

\_\_\_\_\_  
Date