Medical History Form

What is the applicant's diagnosis of disability? (e.g., Down Syndrome, Autism, Cognitively Impaired, Etc.): _____
_____

If you do not have a record of the applicant's immunizations, it may be obtained by contacting your physician. You may include a print out copy of the applicant's immunizations or write them in below. Please check off and give an approximate date for any childhood diseases. If it is not possible to obtain this information, please complete as much as you can and sign.

Childhood Diseases:	**Date:**
( ) Measles (Rubeola)	_____
( ) German Measles (Rubella)	_____
( ) Whooping Cough	_____
( ) Chicken Pox	_____
( ) Mumps	_____
( ) Rheumatic Fever	_____

Immunizations:	**Dates:**
( ) Hepatitis B (HepB)	_____/_____/_____
( ) Diptheria, Tetanus, Pertussis (DTaP)	_____/_____/_____
( ) DPT Booster (within 6 months)	_____/_____/_____
( ) Tetanus (if not given w/DPT)	_____/_____/ _____
( ) Haemophilus influenza type b (Hib)	_____/_____/_____
( ) Inactivated Poliovirus (IPV)	_____/_____/_____
( ) Polio (2 Sabin Trivalent)	_____/_____/_____
( ) Polio Booster (after 6 months)	_____/_____/_____
( ) Measles, Mumps Rubella (MMR)	_____/_____/_____
( ) Rubella/German measles	_____/_____/_____
( ) Rubeola/measles	_____/_____/_____
( ) Mumps	_____/_____/_____
( ) Varicella	_____/_____/_____
( ) Pneumococcal (PCV)	_____/_____/_____
( ) TB test and results	_____/_____/_____

- Complete Both Sides -

Are there any other physical conditions not previously mentioned:
( ) Excessive bleeding ( ) Dizziness ( ) Heat Exhaustion ( ) Skin Irritations;
( ) Menstrual Complications ( ) Diabetes ( ) Allergies (insect stings, hay fever, etc.)
Describe any allergies:

_____
_____

Has the applicant had any serious injuries, operations or hospitalizations?
Yes_____ No_____ If yes, please describe below:

_____
_____
_____

Does the applicant have a restricted or special diet? Yes_____ No_____
If yes, please describe below:

_____
_____
_____
_____

Does the applicant have seizures? Yes_____ No_____
If yes: What type of seizure disorder?_____
Frequency of seizures?_____
Are the seizures controlled? Yes_____ No_____
Does the applicant require a seizure control plan? Yes_____ No_____

Does the applicant use any type of specialized equipment:
Eye Glasses Yes_____ No_____
Hearing Device Yes_____ No_____
Orthopedic Braces Yes_____ No_____
Assistive Technology Yes_____ No_____
Walker/Cane Yes_____ No_____

Does the applicant have any behavioral/safety concerns we should be aware of?
Yes_____ No_____ If yes, please list any suggestions of how to handle them.

_____
_____
_____
_____

I hereby certify that the above information is complete and accurate to the best of my knowledge.

Caregiver Signature:_____

Date:_____

PrimeTime Center
Medication Form

Client's Name:_____

Medications will need to be administered during program hours: Yes_____ No_____

When the administration of medication at PrimeTime Center is unavoidable, PrimeTime Center requires a written statement from the physician. Please have your doctor include the following information and sign the bottom of this page. **Each medication to be administered at PrimeTime Center must be accompanied by a doctor's prescription.**

List all current medications, vitamins and herbals, to be given at PrimeTime Center. All medications must be in their original containers having labels with correct information – see note below *

Medications	Dosage	Times of Administration	Purpose	Side Effects

Parent/Guardian Signature: _____ Date:_____

Physician Signature: _____ Date: _____

*** Note: If there are any changes in medications to be administered, the changes must be accompanied by copies of the new prescriptions in writing provided by the care giver. All listed medications and changes of medications must be reviewed, signed and dated by both the care giver and the physician.**