Family R.O.C.K. Reaching Out to Christ’s Kids

Day Activity Program for Adults with Special Needs

**Physical Exam / Medical Release Form**

A physical examination must be completed by a LICENSED MEDICAL PROFESSIONAL. The exam must be within 12 months of attendance of the session to be attended and provided annually. **If the client is waiting to get an updated physical exam, please include the most recent one available** and send the new one as soon as possible. We do not recommend holding an application while waiting for a physical.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_

Solely to help us comply with government record keeping, reporting and other legal requirements, please check what applies:

White\_\_ Black\_\_ Hispanic\_\_ American Indian/Alaskan Native\_\_ Asian /Pacific Islander\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Notify in Case of an Emergency. (Check if it is the same as above.)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Examination completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Blood pressure: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Normal/Abnormal Normal/Abnormal**

Vision \_\_\_ \_\_\_ Oral cavity \_\_\_ \_\_\_

Cardiovascular system \_\_\_ \_\_\_ Gastrointestinal system \_\_\_ \_\_\_

Cranial nerves \_\_\_ \_\_\_ Reflexes \_\_\_ \_\_\_

Hearing \_\_\_ \_\_\_ Neck \_\_\_ \_\_\_

Respiratory system \_\_\_ \_\_\_ Genitourinary system \_\_\_ \_\_\_

Coordination \_\_\_ \_\_\_ Extremities \_\_\_ \_\_\_

1. Heart disease/heart defect/high blood pressure Yes\_\_\_ No\_\_\_ 13. Allergic to the following:

2. Chest pain or fainting spells Yes\_\_\_ No\_\_\_ Medicines Yes\_\_\_\_ No\_\_\_\_

 3. Seizures/Epilepsy Yes\_\_\_ No\_\_\_ Foods Yes\_\_\_\_ No\_\_\_\_

4. Diabetes Yes\_\_\_ No\_\_\_ Insect sting/bite Yes\_\_\_\_ No\_\_\_\_

5. Concussion or serious head injury Yes\_\_\_ No\_\_\_ 14. Epi-pen Yes\_\_\_ No\_\_\_

6. Major surgery or serious illness Yes\_\_\_ No\_\_\_ 15. Asthma Yes\_\_\_ No\_\_\_

7. Heat exhaustion/stroke Yes\_\_\_ No\_\_\_ 16. Tendency to bleed easily Yes\_\_\_ No\_\_\_

8. Visually impaired/contact lenses/glasses Yes\_\_\_ No\_\_\_ 17. Emotional problems/psychiatric disorder Yes\_\_\_ No\_\_

9. Blindness/major visual problem Yes\_\_\_ No\_\_\_ 18. Sickle Cell trait or disease Yes\_\_\_ No\_\_\_

10. Hearing impaired/hearing aid/hearing loss Yes\_\_\_ No\_\_\_ 19. Immunizations are up to date Yes\_\_\_ No\_\_\_

11. Deaf/complete hearing loss Yes\_\_\_ No\_\_\_ 20. Date of last tetanus: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

12. Serious bone or joint disorder Yes\_\_\_ No\_\_\_ 21. Arthritis Yes\_\_\_ No\_\_\_

Have cervical spine (neck/bone) x-rays been done? Yes\_\_\_ No\_\_\_

Check the following that apply:

Non verbal\_\_\_\_\_\_ Walker\_\_\_\_\_\_ Crutches\_\_\_\_\_\_ Wheelchair\_\_\_\_\_\_ Hepatitis\_\_\_\_\_\_ Shunts\_\_\_\_\_\_

**ALLERGY INFORMATION:** \_\_\_\_\_\_ N/A

|  |  |
| --- | --- |
| List all food, MEDICATION, and/or environmental allergies |  |
| Does the client use an Epi-Pen? | Yes[ ]  | No[ ]  | If yes, why:  |
| Does the client require thickened liquids? | Yes[ ]  | No[ ]  | If yes indicate type:  |
| Lactose intolerant? | Yes[ ]  | No[ ]  |  |
| Gluten intolerant? | Yes[ ]  | No[ ]  |   |
|  |

**SEIZURE ACTIVITY:** [ ]  YES [ ]  NO

How often? [ ]  Daily [ ]  Weekly [ ]  Monthly [ ]  Controlled by medication

Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client have any auras? Describe: ***\_\_\_\_\_\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Describe type, duration, characteristics, known triggers, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIABETES:** [ ]  YES [ ]  NO

If yes: How is it controlled: [ ]  Diet [ ]  Oral Medication [ ]  Insulin

What are the signs/symptoms when low? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the signs/symptoms when high? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood sugar testing? [ ]  YES [ ]  NO If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_times per day.

**ASTHMA OR OTHER RESPIRATORY ISSUES:** [ ]  YES [ ]  NO

If yes: Frequency of attacks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any activity limitations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client use oxygen? [ ]  YES [ ]  NO

**Note to Physicians:**

I have reviewed the above information on and examined the individual named in the application, and certify there is not medical evidence available to me that would preclude the individual’s participation in Family R.O.C.K. activities.

Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician assistant licensed by State Board of Physician Assistant Examiners or registered nurse recognized as an advanced practice nurse by the Board of Nurse Examiners.

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/­­­\_\_\_\_/\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_Physician’s Phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**It is understood and agreed that**: No physician-patient relationship is to arise out of the examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and any person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

**Participation**: I hereby give my permission for the participant named above to participate in any Family R.O.C.K. activity or event of any kind.

**Medical**: I represent and warrant to you that the individual is physically and mentally able to participate in Family R.O.C.K.

**Disclaimer**: On behalf of the individual and myself, I acknowledge that the individual will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Family R.O.C.K. from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the individual.

**Hospitalization**: If I am not personally present at the event in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the individual.

**Media**: In permitting the individual to participate, I am specifically granting permission to you to use the name, likeness, voice and words of the individual in television, radio, films, newspapers, magazines, web pages and other media, and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of Family R.O.C.K. and in appealing for funds to support such activities.

Parent /Guardian/ individual (if over the age of 18) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family R.O.C.K. www.family-rock.org

P.O. Box 507, Kennedale, TX 76060