T21 Social Club Medical Form

Members and Guests of Members Must Complete Form

Participant Name ____

Male ________Female _________ Date of Birth ____

School ____ School District ______________________________

Parent or Guardian ____

Address ____

Home Phone _______________________________________ Mobile Phone ______________________________

Email address ____

Provide Two Emergency Contacts				
	Name	**Relationship**	**Home Phone**	**Mobile Phone**
1				
2				

Identifying Information

Age______ Weight ______ Height ______ Hair Color____________ Eye Color _____________Current Photo Attached ❒

Personal History

SELF CARE Needs help with ____

EATING Does individual need assistance in cutting food/meat? ❒ Yes ❒ No

Does individual have difficulty swallowing? ❒ Yes ❒ No

DIET Special Diet ____

List food problems or allergies ____

____

HEARING ❒ Normal ❒ Mild Loss ❒ Severe Loss ❒ Total

VISION Uses ❒ Glasses ❒ Contact Lenses ❒ None ❒ Other ________________________________

SPEECH ❒ Normal ❒ Mild ❒ Moderate

COMMUNICATION ❒ Normal ❒ Sign Language ❒ Communication Board ❒ Gestures

❒ Other ____

MOBILITY ❒ Needs Assistance ❒ Walks with Walker/Braces/Crutches ❒ Uses Wheelchair (circle Manual/Electric) ❒ Other, please explain ________________________________

ADAPTIVE DEVICES ❒ Braces ❒ Wheelchair ❒ Prosthesis ❒ Helmet ❒ Hearing Aid ❒ Shunts

❒ Other ____

TOILETING Is individual toilet trained? ❒ Yes ❒ No

Does Individual wear training pants? ❒ Yes ❒ No

Does individual wear diapers? ? ❒ Yes ❒ No

Individual needs to be taken to the bathroom every _______ hours.

Please state problems with **personal care** staff should know about ________________________________

____

Does the applicant have any phobias/fears? ❒ Yes ❒ No If yes, please list ________________________

Explain desired approach if individual encounters a known fear ________________________________

____

Can the individual swim? ❒ Yes ❒ No ❒ Other ____

Is he/she afraid of the water? ❒ Yes ❒ No

Is there any activity in which the person cannot participate? ❒ Yes ❒ No If yes, please list ________________

____

Does individual wander? ❒ Yes ❒ No If yes, please explain ________________________________

____

Is he/she a runner? ❒ Yes ❒ No If yes, please explain ________________________________

List individual's hobbies/interests ____

Behavior (see Behavior Policy)

Does the individual have behavior problems? ____

____

What situations contribute to the behavior above? ____

____

Are you currently using a behavior plan that you would like to share with us? ______________________

____

Does your child have seizures? ❐ Yes ❐ No If yes, please explain ______________________________

Does your child allergies? ❐ Yes ❐ No If yes, please explain ______________________________

____

Medications (Attach a copy of current insurance card)

Medication	Dosage	Frequency (daily, etc.)
Purpose	**Taken** ❐ Orally ❐ Topically ❐ Other________________	**Adverse Side Effect**
Medication	**Dosage**	**Frequency (daily, etc.)**
Purpose	**Taken** ❐ Orally ❐ Topically ❐ Other________________	**Adverse Side Effect**
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Return Medical Form to T21 Social Club c/o Friends of Down Syndrome, 5200 Mitchelldale, Suite D4, Houston, TX 77092. You may fax to 1-866-566-9530. Scans may be emailed to president@friendsofdownsyndrome.org.