MEDICAL EVALUATION

Name: ________________________________ Birth Date: _____________ Sex: _______

Personal Physician:____

Diagnosis, Disabilities and Handicaps: ______________________________
____
____
____

Known Allergies: ____
____
____

Medications: ____
____
____

Diet: ____

Height: ___________ Weight: __________ Temp: ___________ Blood Pressure: __________

General Evaluation:_______________________________________
____
____

Hearing Impairment: ☐ Yes ☐ No Visual Impairment: ☐ Yes ☐ No

Comment only if disabling conditions exist:

Respiratory System: ___________________________________
Circulatory System: ___________________________________
Heart Problem/Defect: _________________________________
Mental or Emotional Abnormalities: _____________________

Major Impairments Are (Select One):
☐ None ☐ Temporary ☐ Status Quo ☐ Progressive

Is additional information needed to make proper evaluation: ☐ Yes ☐ No

If yes, what? ____
____
____

Free from Communicable disease? ☐ Yes ☐ No

I ☐ Recommend ☐ Do Not Recommend that a Guardian be appointed.

_______________________________________ __________________
Physician Signature Date

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