Respite Program Medical History & Physician's Statement

Child's Name:	DOB:	Height:	Weight:
Address:			
Diagnosis:		Date of Onset:	
Past/Prospective Surgeries:			
Medications:			
Seizure Type:	Controlled: Y N	Date of Last Seizure:	
Shunt Present: Y N	Date of last revision:		
Special Precautions/Needs:			
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N			
Braces/Assistive Devices:			

Please indicate current or past special needs in the following systems/areas, including surgeries

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Name/Title:	MD DO NP PA Other	
Signature:		Date:
Address:		
Phone:	License/UPIN Number:	

When completed please scan and email to The Brave Warrior Project
beth@thebravewarriorproject.com