To be completed by Physician

Name of Child/Adult___________________________ Date of Birth (m/d/y): __________

Diagnosis: ____

Medications: ______________________________ Allergies: ____________________

Any corrective or recent surgery: ____

Seizures: Yes ____ No ____ Date of last seizure: ___________________________
Are seizure controlled by medication? Yes ___ No___

Tetanus immunization and date of most recent shot: ____________________________

Vision: ____

Hearing: ____

Receptive language: Normal _______ Moderate __________ Minimal ___________

Expressive language: Normal _______ Moderate __________ Minimal ___________

Sensation (please note any areas of diminished or absent sensation): _____________
____

Muscle tone:
Upper extremity: Normal _________ High __________ low_________ other_________

Lower extremity: Normal _________ High __________ low_________ other_________

Neck/Trunk: Normal _________ High __________ low_________ other_________

Ambulatory: Yes________ No _________

Balance:
Sitting: Normal _______ Moderate __________ Minimal _________

Standing: Normal _______ Moderate __________ Minimal _________

Walking: Normal _______ Moderate __________ Minimal _________

I hereby give permission for the above individual to participate in the EAPD (FLF) program at Roycan's Country Haven.

Physician signature: ____Date:__________

Physician name and number (please print): ___________________________________