MEDICAL EVALUATION

Individuals Name: **Waiver:**

I.	**System Disorder**	**Name of Condition**	**Date of Onset**	**Circle One**	
	a. Respiratory			**Yes**	**No**
	b. Cardiovascular			**Yes**	**No**
	c. Gastro-Intestinal			**Yes**	**No**
	d. Genito – Urinary			**Yes**	**No**
	e. Neurological			**Yes**	**No**
	f. Other			**Yes**	**No**

II.	**History of Seizures (Type)**	**Date of Onset**		
	Simple Partial (Simple motor movements/no awareness loss)		**Yes**	**No**
	Complex Partial (Loss of awareness)		**Yes**	**No**
	Generalized – Absence (petit mal)		**Yes**	**No**
	Generalized – Tonic-Clonic (grand mal)		**Yes**	**No**
	Controlled with medication		**Yes**	**No**
	Other:_____			
	Seizure Frequency per month:			

III.	**Disability**	**Date of Onset**		
	Mental Retardation		**Yes**	**No**
	Autism		**Yes**	**No**
	Cerebral Palsy		**Yes**	**No**
	Mental Illness		**Yes**	**No**
	Other: _____			

IV.	**Sensory/Motor Limitation**		
	Hearing	**Yes**	**No**
	Vision	**Yes**	**No**
	Ambulatory	**Yes**	**No**
	Fine Motor Deficit	**Yes**	**No**
	Major Motor Deficit	**Yes**	**No**
	Communication	**Yes**	**No**

V.	**Treatment Modality**		
	Physical Therapy	**Yes**	**No**
	Occupational Therapy	**Yes**	**No**
	Speech Therapy	**Yes**	**No**
	Special Diet Type: _____		
	Other: _____		
	(IV, Tube Feed, O_2 , Catheter, etc.)		
	Special Equipment _____		

VI. Medications: (Use reverse side of this sheet for additional medications)

Individual can self medicate: **Yes** **No**

Medication	**Dose**	**Related Diagnosis or Condition**

VII. Physician Signature

_____ _____ _____

Physician Name (print) **Physician Signature** **Date**

Medication (Name)	Dose	Related Diagnosis or Condition