Parent Health and Medical History Form

Participant Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Please complete the following which addresses special needs and/or concerns to bring to our attention:

YES NO COMMENTS

VISION

HEARING

SENSATION

COMMUNICATION

HEART

BREATHING

DIGESTION

CIRCULATION

EMOTIONAL

BEHAVIORAL

PAIN

BONE/JOINT

MUSCULAR

COGNITION/THINKING

NEUROLOGICAL

DOWN SYNDROME

LEARNING DISABILITIES

(SPECIFY)

OTHER

Describe abilities/difficulties in the following areas (include assistance required or equipment needed)

Functional (ie mobility skills such as transfers, walking, wheelchair use, driving, bus riding)

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SOCIAL (ie Work/school including grade completed, leisure interests, relationships-family structure