# Medical Exam Report Update

_______________
Date

| | |
|---|---|
| Child's Last Name First Middle | Parent/Guardian Last Name First |
| Date of Birth Sex | Telephone - Home |
| Street Address | Cell Phone |
| City, State Zip Code | Work Phone |
| Height ______________ Weight _________<br>BMI ______________ Pulse __________<br>Respiration____________ BP __________<br><br>Diagnosis ____________________________________<br><br>Significant changes ______________________________<br>______________________________________________<br><br>Known Allergies ________________________________<br>Asthma/Seasonal allergies ____yes ____no<br>OTC Medication recommendation for: _______________<br><br>______________________________________________ | Current Medications:<br><br><br><br>Current Diary restrictions/recommendations: |

Activity restriction ______________________________________________________________________________
Recommended for follow up services/tests/referrals _____yes _____no
Hearing ______ Vision ______ Dental ______ other specialist _______________________
PT ______ OT ______ Speech ______ Dietary______ Swallow study ______
Other _________________________________________________________________________________________

This child ______**is** ______**is not** Medically stable to participate in the Interactive Sensor motor Program at The Elaine Clark Center

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|---|---|
| Physician's Stamp or:<br>Clinic Name<br>Address<br>City/zip<br>Phone<br><br>______________________________________________<br>Physician Signature Date | |

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