



Medical Information Form

Participant Name _____

Doctors Name _____ Doctor Number _____

Emergency Contact Name _____

Emergency Contact Number _____

Primary Medical Insurance Company _____

Policy Holder (name) _____ Policy Number _____

Primary Disability _____ Date of Onset _____

Secondary Disability _____ Date of Onset _____

Date of Last Tetanus Shot _____

Are all of your immunizations up to date? Yes No If not, please specify which immunizations are currently not up to date:

Do you have any allergies(i.e. latex) Yes No

If so, please be specific in describing the symptoms of an allergic reaction:

Current Medications (include name and dosage):

Please list any previous surgeries and dates on which they were preformed:

_____ Date _____

_____ Date _____

_____ Date _____



History of Seizures: Yes No If yes, give date of most recent _____

Do you have a shunt? Yes No Date of original shunt _____

Have you had any shunt revisions? Yes No Date of revision _____

Do you have a history of heart disease, heart problems or high blood pressure?

Yes No If yes, please explain

Have you ever had a brain injury or concussion? Yes No if yes, please give the approximate date and describe the incident

Do you have any problems with (mark all that apply):

Overheating Autonomic Dysreflexia Pain

If any apply, please describe

Do you have scoliosis? Yes No Have you had a back fusion? Yes No

If yes, what level? _____

Do you currently have any pressure sores? Yes No If yes, where are they and how are you treating them?



Are you continent of bladder? Yes No

Are you continent of bowel? Yes No

What type of bladder management do you use?

None indwelling catheter intermittent catheter

If intermittent, what is your cathing schedule? _____

Parent/ Guardian Name _____

Parent/ Guardian Signature _____