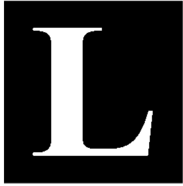

Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314
Phone: 718-983-5351 ● Fax: 718-983-5383 ● www.lfdsi.org

Name: ______________________________ **DOB:**________________ **Date:**________________

A Medical Examination is required to be completed by a licensed physician, as is medically necessary, to meet health needs and to ensure fitness to participate in agency activities. Please notify the agency if the participant is exposed to any communicable diseases and/or has any medication changes.

PHYSICAL EXAMINATION

Height: ____________ Weight: ____________ Blood Pressure: ____________

Temperature: ____________ Pulse: ____________ Respiration: ____________

Head: ____________ GU: ____________

Eyes: ____________ Skin: ____________

Ears: ____________ Rectal: ____________

Nose: ____________ CNS: ____________

Throat: ____________ Musculoskeletal: ____________

Neck: ____________ Extremities: ____________

Lungs: ____________ Allergies: ____________

Breasts: ____________ ____________

Heart: ____________ Diagnosis: ____________

Abdomen: ____________ ____________

CURRENT TEST RESULTS / STATUS

Hgb. Test: ____________
Results *Date*

Urinalysis: ____________
Results *Date*

PPD: ____________
Results *Date*

TD Booster: ____________
Date

HB Screening: ____________
Results *Date*

HB Vaccine: ____________
Date

Other: ____________
Name of Test *Results* *Date*

Operations: ____________

Serious Injuries: ____________

Chronic or Recurring Illnesses: ____________

Name:____

CURRENT MEDICATION(S) OR NONE

Type	Dosage / Frequency	Condition

Diet / Nutritional Requirements: ____

____

____

RESTRICTIONS WHILE IN PROGRAM

This individual is NOT to participate in the activities checked below:

☐ Swimming / Diving ☐ Use of Stairs ☐ Strenuous Activities ☐ Other: ______________________

PLEASE NOTE ANY RISK FACTORS BELOW:

☐ Obesity ☐ COPD/Asthma ☐ PVD/Claudication ☐ Hypertention

☐ Diabetes ☐ CHF/Myopathy ☐ Arrhythmia ☐ Hypotension

☐ Syncope ☐ CVD/CAD ☐ Seizures ☐ Other:______________________

I have examined the person described above, and have reviewed his/her health history. It is my opinion this individual is physically able to participate in program activities, except as noted above.

______________________________________ ______________________

Physician Signature Date

______________________________________ ______________________

Address Telephone Number