Via Services, Inc.
2851 Park Ave, Santa Clara, CA 95050
Phone (408) 243-7861 ext. 214
Fax (408) 243-0452

Please note:

This form is good for two years from the date EXAMINED, not date form is signed.

MEDICAL FORM (TO BE SIGNED BY A LICENSED PHYSICIAN)

PATIENT (PARTICIPANT) NAME:_____BIRTHDATE _____

HEALTH EXAMINATION BY LICENSED PHYSICAN

I have examined the above named individual. **Date of exam:**_____Form expires two years from THIS DATE.
In my opinion, the above named individual's condition ☐ **does** ☐ **does not (check one)** allow for participation in this program.

Participant's disability _

DISABILITY INVOLVES

(Check, if applicable, giving approximate dates)

☐ Legs	☐ Head/Neck	☐ Breathing	☐ Learning
☐ Arms	☐ Vision	☐ Communication	☐ Social Adjustment
☐ Hands	☐ Hearing	☐ Speaking	☐ Behavior
☐ Trunk	☐ Coordination	☐ Understanding	☐ Other _____

HEALTH HISTORY

(Check, if applicable, giving approximate dates)

☐ Diabetes	☐ Heart Defect/Disease	☐ Bleeding/Clotting Disorder	☐ Asthma
☐ Frequent Ear Infections	☐ Hay Fever		☐ Measles
	☐ Chicken Pox	☐ Mumps	☐ Mononucleosis
☐ Hypertension	☐ German Measles (Rubella)		☐ Other _____

ALLERGIES (PLEASE LIST ALLERGY & REACTION)

Medication:_____
Foods:_____
Environment:_____

DOES THE PATIENT HAVE SEIZURE DISORDER? ☐ YES ☐ NO Date of last known seizure:_____

Type and frequency: _____

_____

List any specific Seizure Protocol:

_____

_____

RECOMMENDATION OF RESTRICTIONS AT VIA SERVICES' PROGRAMS

Treatment plan to be continued while attending programs:

_____

_____

Activity restriction, if any_____

Signature of Licensed Physician:_____Phone_____
Print Name of Licensed Physician:_____Address: ___
City_____State_____Zip Code___Date of Form Completion:_____Completed By:_____

MEDICAL FORM (TO BE SIGNED BY A LICENSED PHYSICIAN)

PATIENT (PARTICIPANT) NAME:_____BIRTHDATE _____

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Polio	Diphtheria Pertussis Tetanus	Measles Mumps Rubella	Hepatitis	Pneumococcal	TB Test Given
☐ 2-4 months ☐ 15 months ☐ 5 years ☐ Other Date _____	☐ 2-4 months ☐ 6 months ☐ 18 months ☐ 5 years Date _____	☐ 12-15 months ☐ 11-12 years ☐ Other Date _____	☐ Hep A Date _____ Date _____ ☐ Hep B Date _____ Date _____	Date _____ Date _____ Date _____	☐ TB Test Given Date _____ ☐ Negative ☐ Positive

PLEASE LIST ALL MEDICATIONS

(INCLUDING OINTMENTS & TOPICALS, SUPPLEMENTS, VITAMINS, AND OVER THE COUNTER PRODUCTS, SUCH AS IBUPROFEN

Medication & Dosage	Times given	Route	Reason	Special instructions/ side effects

Signature of Licensed Physician:_____Phone_____

Print Name of Licensed Physician:_____Address: ____

City_____State_____Zip Code____Date

of Form Completion:_____Completed By:_____

MEDICATION LIST (CONTINUED)
(PLEASE ATTACH ADDITIONAL SHEETS IF NEEDED)

Medication & Dosage	Times given	Route	Reason	Special instructions/ side effects

Signature of Licensed Physician:_____Phone_____
Print Name of Licensed Physician:_____Address: ___
City_____State_____Zip Code___Date
of Form Completion:_____Completed By:_____