

2001 CHAMPIONSHIP GOLD

GENERAL MEDICAL INFORMATION

This form must be filled out by a physician, nurse practitioner
or physician's assistant and signed by same.

Dear Doctor: Your patient is planning on participating (provided you agree) in various athletic events and/or games which may be strenuous and/or dangerous depending on their condition. We ask you to take this into consideration when reviewing the participant's history and exam.

Patient Name (Please print) _____ Date _____
Last First M.I.

Social Security # _____ Age _____

PARTICIPANT'S RESIDENCE (please check one) HOME _____ NURSING HOME _____
IN PATIENT _____ VA DOMICILIARY _____ OTHER _____

Address _____
City, State _____ Zip _____
Participant's Daytime Phone # (____) _____ Evening (____) _____

NAME OF VAMC _____

WHO IS HIS/HER COACH? _____ Phone (____) _____

HAS THE PARTICIPANT COMPETED IN THE GOLDEN AGE GAMES BEFORE?
YES / NO When? _____

HAS HE/SHE HAD A MEDICAL PROBLEM AT GOLDEN AGE GAMES BEFORE?
YES / NO IF YES, PLEASE EXPLAIN _____

MEDICAL HISTORY _____

SIGNIFICANT PHYSICAL FINDINGS (e.g. wheelchair bound, dementia, dialysis patient,
Hemiplegic, severely arthritic, severe COPD, etc.)

DIAGNOSES: _____

Name _____ Social Security Number _____
Last First M.I.

CURRENT MEDICATIONS: (List each or send current Action Profile) _____

CAN HE/SHE CONTROL THEIR OWN MEDS? YES / NO

ALLERGIES: _____

WHAT EQUIPMENT WILL THEY BRING DURING HIS/HER STAY?

Raised toilet seat _____ Shower Chair _____ Wheelchair _____ Hoyer Lift _____
Other _____

WHAT EQUIPMENT NEEDS TO BE PROVIDED?

Raised toilet seat _____
Shower Chair _____ Wheelchair _____ Hoyer Lift _____ Other _____

ANY SPECIAL NEEDS?

(e.g. feeding tube, tracheotomy, catheter, mobility, bladder and bowel care, etc.)

IF YES, WHAT? _____

WHO IS RESPONSIBLE FOR THESE SPECIAL NEEDS? _____

DOES THE PARTICIPANT NEED ASSISTANCE? YES / NO

If yes – with what? _____

IS ASSISTANCE COMING WITH THE PARTICIPANT? YES / NO

(nurse, therapist, family member) If yes – who is it? _____

WHAT ACTIVITY RESTRICTIONS IF ANY EXIST? _____

PLEASE INCLUDE A COPY OF CURRENT EKG

In the **examining physician's opinion**, the above individual:

_____ **Is cleared to compete** _____ **Is not cleared to compete**

Doctor's signature _____

Doctor's printed name _____

Address _____

VAMC _____

PLEASE READ

Participants are responsible for bringing enough medication for the week, arranging for any special equipment and/or care they need, and assistance if they need it. **Physicians and nurses are provided to take care of emergencies and illnesses ONLY.** Routine care must be provided by the participants and/or the VAMC sponsoring them.