Brain Injury Alliance COLORADO

Participant Medical Form

Applicant's Name: _____ Date: ____/____/____

Section Two: For Your Doctor to Complete

This Medical Form must be completed by the participant's doctor once annually.

Medical History:

1. Chronic health problems (e.g. asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware: _____
   _____.

2. Applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B: ☐ Yes ☐ No
   If yes, was a lab test conducted to determine the presence of antibodies? ☐ Yes ☐ No
   Were antibodies present? ☐ Yes ☐ No Physician's initials _____

3. Applicant a carrier of any other infectious or contagious condition: ☐ Yes ☐ No
   Explain: _____

4. Allergies: ☐ Yes ☐ No Describe: _____

5. Seizures: ☐ Yes ☐ No Type: _____
   Date of the last one: ____/____/____
   Are they controlled by medication? ☐ Yes ☐ No What: _____
   Can applicant tell if one is coming on? ☐ Yes ☐ No How: _____

6. Vitals: ☐ Heart problems ☐ Heart murmur ☐ Irregular heart beat ☐ Blood pressure concerns
   Explain: _____
   Problems at higher elevation: ☐ Yes ☐ No Explain: _____

7. Applicant's immunization records up-to-date and complete: ☐ Yes ☐ No
   Date of last tetanus shot: ____/____/____

Applicant's Name: _____ Date:_____/_____/_____

Medications: List all medications currently taken by the applicant. Please attach additional sheet(s) if needed.

	Med. Name	Dosage Times	Total/Day	Reason Prescribed
1.				
2.				
3.				

Describe how the applicant best takes the medication(s).

Over the counter ANYTHING: _____

_____ Doses: _____

Vitamins and Herbs: _____

_____ Doses: _____

Restrictions:

1. Has the applicant been hospitalized or treated in an emergency room recently? ☐ Yes ☐ No
   If yes, please explain _____
2. Physical conditions, past operations or injuries which might restrict program activity? ☐ Yes ☐ No
   Explain restrictions _____
3. Pulse Oxide Range _____ to _____

Physician Signature: _____ **Date:**_____/_____/_____

Physician's Name (Please Print):_____

Office Phone: _____ **Emergency Phone:** _____

Brain Injury Alliance COLORADO

Send your completed form with PHYSICIAN'S SIGNATURE to:

Michael Zavala
1325 S. Colorado Blvd., B300
Denver, CO 80222

Michael@BIAColorado.org
(303) 562-0401
Fax (303) 355-9968

BIAColorado.org