

MEDICAL EVALUATION

Individuals Name:		Waiver:	
I.	System Disorder	Name of Condition	Date of Onset
	a. Respiratory		Circle One Yes No
	b. Cardiovascular		Yes No
	c. Gastro-Intestinal		Yes No
	d. Genito – Urinary		Yes No
	e. Neurological		Yes No
	f. Other		Yes No
II.	History of Seizures (Type)	Date of Onset	
	Simple Partial (Simple motor movements/no awareness loss)		Yes No
	Complex Partial (Loss of awareness)		Yes No
	Generalized – Absence (petit mal)		Yes No
	Generalized – Tonic-Clonic (grand mal)		Yes No
	Controlled with medication		Yes No
	Other: _____		
Seizure Frequency per month:			
III.	Disability	Date of Onset	
	Mental Retardation		Yes No
	Autism		Yes No
	Cerebral Palsy		Yes No
	Mental Illness		Yes No
	Other: _____		
IV.	Sensory/Motor Limitation		
	Hearing		Yes No
	Vision		Yes No
	Ambulatory		Yes No
	Fine Motor Deficit		Yes No
	Major Motor Deficit		Yes No
	Communication		Yes No
V.	Treatment Modality		
	Physical Therapy		Yes No
	Occupational Therapy		Yes No
	Speech Therapy		Yes No
	Special Diet Type: _____		
	Other: _____		
	(IV, Tube Feed, O ₂ , Catheter, etc.)		
	Special Equipment _____		
VI.	Medications: (Use reverse side of this sheet for additional medications)		
	Individual can self medicate:	Yes	No
	Medication	Dose	Related Diagnosis or Condition
VII.	Physician Signature		
Physician Name (print)	Physician Signature	Date	

