MEDICAL PROVIDER FORM

TO MEDICAL SPECIALIST:
Zebra Crossings' programs are leisure and recreational in nature and require a basic level of physical and mental capacity. Programs can and will be generally adapted to individual's needs with the proper notification. Examples of activities in our programs include but not limited to swimming, basic trail bike ride, kayaking, cooperative games, challenge courses or climbing walls. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitation of this participant in our program.

This form verifies the date of the child's last physical, and physician recommendations for level of participation in our programs. It must be completed and signed by child's medical specialist every year.

Parents are responsible for informing Zebra Crossings in writing of any changes in their child's health condition, including physical, mental and emotional needs.

Name of Child ______________________________ Date of last office visit and examination ___________

Height: ________ Weight: ________ BP: ________ HR: _________ RR: _________

Please list past pertinent medical history: (use back if necessary)

____

____

____

How well controlled is this child's medical condition at this time:

____

____

____

Medical device information:

____

____

____

Daily medications (ALL medications, including Psychological):

____

____

____

PRN Medications and frequency of use:

____

____

Activity Level: Please circle one of the letters below indicating the level of activity at which the applicant is able to participate in our activities.

A FULL ACTIVE PARTICIPATION WITH MODERATE EXERCISE
Participates in non-competitive games which may involve running short distances, repetitive motion and/or swimming.

B PARTIAL ACTIVE PARTICIPATION WITH LIGHT EXERCISE
Participates in limited activities (such as nature walks) and rests occasionally.

C LIMITED ACTIVE PARTICIPATION WITH NO EXERCISE
Must rest frequently; participates in sedentary activities only (such as craft projects).

Summary of Active Concerns/Restrictions which would preclude child from participating fully in recreational programs (diet, medical, swimming, athletic, psychological):

☐ None or list below:

____

____

____

- ☐ Please attach a copy of any medical action plans, e.g. Asthma Action Plan, Seizure Action Plan, Diabetes Treatment Plan.

Additional comments:

PHYSICIAN SIGNATURE REQUIRED

Please return this form to the applicant's family upon completion. Your signature verifies the above information to be current and accurate. Thank you.

Physician Name: ______________________________ How long have you known the participant? _______

Address: ____

Phone Number: ______________________________ Alternate phone: ________________________

Physician signature ______________________________ Date ____________

Practice Name: ____

☐ Some of my other patients may benefit from attending Zebra Crossings. Please send me a few brochures.