LEADER DOGS
FOR THE BLIND

MEDICAL HISTORY & PHYSICAL EXAMINATION

FOR TEEN SUMMER CAMP

(To be completed by a Physician)

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Our mission is to empower people who are blind or visually impaired with lifelong skills for safe and independent daily travel.

Medical History

(To be completed by a Physician)

Applicant Name _____

Applicant Address _____ City/St/Zip _____

Physician Name _____ Telephone _____

Physician Address _____ City/St/Zip _____

Has the patient had any of the following medical problems?

Arthritis	Yes/No	Lung Disease	Yes/No
Emphysema	Yes/No	Asthma	Yes/No
Coughing Blood	Yes/No	Seizure/Epilepsy	Yes/No
Fainting Spells	Yes/No	Diabetes/Low Blood Sugar	Yes/No
Hearing Impairments	Yes/No	Ear Infections	Yes/No
Problems Sleeping	Yes/No	Nervous Disorder	Yes/No
Psychiatric Problems	Yes/No	Cancer	Yes/No
Heart Disease	Yes/No	Chest Pain	Yes/No
High Blood Pressure	Yes/No	Allergies of any kind	Yes/No
Head Trauma	Yes/No		

Surgery or Hospitalization for any reason (please explain) _____

_____

Serious Injuries or Accidents _____

History of Seizure or Epilepsy (please explain) _____

Approx. date of last seizure _____ Severity _____ Frequency _____

Duration of seizure _____ Can patient detect seizure? _____

Has patient been hospitalized due to seizure? _____

Has seizure medication been checked? _____ Is it normal? _____

DOCTOR'S COMMENTS – Give details to any item checked 'YES' from above list. (Please print)

_____

_____

Signature _____, M.D./D.O. Date _____

Physical Examination

(To be completed by a Physician)

Applicant Name _____

Current Health Conditions _____

_____

_____

Height _____ Weight _____

HEENT _____ Neck _____

Chest _____ Heart _____

Abdomen _____ Genitalia _____

Extremities _____ CNS _____

Blood Pressure _____ / _____ Pulse _____

Cause of Blindness _____

Hearing Test: Please note "IN FEET" how far from the patient you were when testing for:

Spoken word _____ Right _____ Left _____

Whispered word _____ Right _____ Left _____

Does patient wear hearing aids? ☐ Yes ☐ No If yes, type ☐ BTE ☐ ITE ☐ EG ☐ CROS

Is Aid T-coil equipped: ☐ Yes ☐ No

Sound localization intact? ☐ Yes ☐ No Does patient move head to localize? ☐ Yes ☐ No

If patient has hearing loss, please include or forward recent audiometric data.

COMMENTS _____

_____

List any allergies _____

IN YOUR OPINION, CAN THE PATIENT WALK AT A REASONABLE PACE FOR ½ HOUR OR MORE WITHOUT JEOPARDIZING ANY CURRENT HEALTH PROBLEMS? ☐ Yes ☐ No

List any impairment of the use of either arm/hand _____

List any impairment of the use of either leg/foot _____

List any emotional problems _____

Last EKG (date) _____ Last Chest X-Ray (date) _____

If available and applicable, please send a copy of patient's last EKG and results of latest chest x-ray or recent stress test. These will be used if the applicant needs to be seen by a physician while in training.

Signature: _____ M.D./D.O. Date _____

Medication Form

Supplement to Application for Leader Dog Training

(To be completed by a Physician)

Applicant Name _____

Please list all medications being taken:

Medication	Dosage	Condition/Illness	Special Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate any current or anticipated surgery and/or radical treatment _____

_____

Is applicant current on all routine vaccinations? ☐ Yes ☐ No: _____

Can applicant inject own insulin? ☐ Yes ☐ No

Can applicant test own sugar level? ☐ Yes ☐ No Method Used _____

Is applicant aware of impending hypoglycemic episodes? ☐ Yes ☐ No

List any special dietary requirements _____

Does applicant smoke? ☐ Yes ☐ No

Is applicant bothered by others smoke? ☐ Yes ☐ No

Applicant has been a patient since _____

Date of last previous physical exam _____

Signature _____ M.D./D.O. Date _____

Name _____

Address _____

City/St/Zip _____

Phone (_____)_____

PLEASE TYPE OR PRINT