EAST PROVIDENCE RECREATION DEPARTMENT
SPECIAL NEEDS MEDICAL FORM

PARTICIPANTS MUST RETURN THIS FORM COMPLETED BY:
PHYSICIAN & PARENT/GUARDIAN

RETURN TO: East Providence Recreation Department
610 Waterman Avenue, East Providence, RI 02914 PH:435-7511 / FAX: 563-7024

Please Type or Print Clearly

Participant's Name_____Birthdate_____Sex_____

Address_____Zip_____

Home Phone_____Emergency Phone_____

Diagnosis_____Medication(s)_____

Significant Condition(s)/Operation(s)/Illness_____

Medical Information		**Explanations/Comments**
Allergies	Yes____No____	_____
Seizures	Yes____No____	_____
Dietary Restrictions	Yes____No____	_____
Physical Limitations	Yes____No____	_____
Hearing Loss	Yes____No____	_____
Visual Complications	Yes____No____	_____
Speech Difficulties	Yes____No____	_____
Heart Difficulties	Yes____No____	_____

May applicant participate in swimming activities? Yes_____No_____

Needs to wear nose clip? Yes____No_____ Can he/she dive? Yes____No____

Needs to wear ear plugs? Yes____No_____ Can he/she put face under water? Yes____No____

Other Precautions: _____

Is participant, to your knowledge, suffering from or has he/she recently been exposed to any contagious disease?_____

Physician's Signature_____Date_____

Physician's Address_____Phone_____

Parent/Guardian or Participant must complete the following:

In case of MEDICAL EMERGENCY, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the East Providence Recreation Department to take such measures and arrange for such medical and hospital treatment as may be deemed advisable for the health and well-being of participant.

Signature of Parent/Guardian_____Date_____