Joy's SCHOOL OF DANCE, INC.

Camp Hope Therapy Team

Occupational, Physical and Speech Therapy for Children

Ballerina Dreams

Physician's Statement

Dear Physician:

Your patient _____ is interested in participating in supervised dance related activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that some conditions may suggest precautions and contraindications to dance related activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation dance related activities, please feel free to contact the program at 254-644-2423

Participant: _____ D.O.B. _____ Diagnosis: _____
Address: _____ City: _____ Zip: _____
Past/Prospective Surgeries: _____
Medications: _____

Seizure Type: _____ Controlled: ☐ Y ☐ N Date of Last Seizure: _____

Shunt Present: ☐ Y ☐ N Date of last revision: _____
Special Precautions/Needs: _____
_____

Mobility: Independent Ambulation ☐ Y ☐ N Assisted Ambulation ☐ Y ☐ N

Wheelchair ☐ Y ☐ N Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

To my knowledge, there is no reason why this person cannot participate in supervised dance related activities. However, I understand that Joy's School of Dance and Camp Hope Therapy Team will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP) in the implementations of an effective program.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Phone: ( ) _____ NPI Number: _____

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Participant's Medical History

Participant: _____ D.O.B. _____ Diagnosis: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Allergies			
Auditory			
Balance			
Cardiac			
Circulatory			
Blood Pressure Control			
Hemophilia			
Cognitive			
Dangerous to self or others			
Emotional/Psychological			
Hydrocephalus/Shunt PVD			
Immunity			
Integumentary / Skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Osteoporosis			
Joint subluxation / dislocation			
Pathologic Fractures			
Spinal Fusion/Fixation			
Spinal Instability			
Pain			
Migraines			
Pulmonary			
Respiratory			
Seizure			
Speech			
Tactile Sensation			
Visual			
Other:			