



MEDICAL PROFILE from Physician

To be completed by a licensed physician and mailed or faxed to the Tourette Syndrome Association of Texas
Health certification **MUST** be dated within 8 weeks of participation in Program.

CHILD'S NAME: _____
Last
First
Middle Initial

Sex: M _____ F _____ Age: _____ Wt.: _____ B/P: _____ Allergies: _____

Explain below using code: ✓ - Satisfactory X- Not Satisfactory

Eye _____ Ears _____ Nose _____ Throat _____ Heart _____ Lungs _____ Abdomen _____ Skin _____ Extremities _____

Abnormal Findings _____

Diagnosis _____

Other chronic or recurring illnesses or handicapping conditions _____

Describe any associated behavioral difficulties _____

List all medications child is currently taking.

MEDICATION NAMES	STRENGTH	FREQUENCY

Are all immunizations up to date? Yes _____ No _____

Special instructions/Comments/Limitations: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in program activities as noted above.

 Examining Physician Date () Phone Number () Fax Number