BLAST OFF
CHILDREN'S THERAPY SERVICES

MEDICAL UPDATES

Client Name: _____ Date of Birth: _____

Emergency Contact Name/Phone #: _____

1. DIAGNOSES: (List all)

   _____

2. SEIZURES: YES NO

   If "yes" please clearly describe what the seizures look like when they occur, what restrictions if any your child has due to seizures, and protocols to follow if seizures occur during session.

   _____

   _____

   _____

3. ALLERGIES: YES NO

   If "yes" please clearly state what your child is allergic to, the reaction your child has, and protocols to follow if a reaction occurs during the session.

   _____

   _____

   _____

4. ARE THERE ANY OTHER RESTRICTIONS THAT BLAST OFF SHOULD KNOW ABOUT OR PROTOCOLS THAT SHOULD BE FOLLOWED DUE TO ANY MEDICAL DIAGNOSES YOUR CHILD HAS? YES NO

   If "yes" please clearly state restrictions/protocols.

   _____

   _____

   _____

_____

Signature of Parent/Guardian/Responsible Party Date

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