OMB Number:
Respondent Burden: 20 minutes

Department of Veterans Affairs

PARTICIPANT MEDICAL INFORMATION FORM

NATIONAL VETERANS CREATIVE ARTS FESTIVAL

(To be completed by Clinician, Physician, Psychiatrist, Nurse Practitioner or Physician Assistant and signed by the same)

PRIVACY ACT: VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

*Attention veteran: Please schedule an appointment with your primary provider as soon as possible. Bring this form to your appointment. Your provider must complete this form. Please return this form along with your completed registration forms by _____ .

Dear Clinician: Your patient has been invited to attend the National Veterans Creative Arts Festival in _____ . Activities that he/she may be engaging in include rehearsing and performing music, dance, and drama acts or original writing selections for the public, or participating in visual art workshops, exhibits, and local art gallery touring opportunities.

If you agree that this patient is able to participate in the above activities, we ask that you complete the following information. The information that you provide will assist the medical team with providing appropriate care. Clinicians and nurses working with the Festival are provided to take care of emergencies and illness only. Routine care is the participant's responsibility.

PATIENT'S NAME	SOCIAL SECURITY NUMBER *(Last 4 digits only)*	DATE OF BIRTH	AGE

PATIENT'S ADDRESS *(City, State and Zip Code)*	VA MEDICAL FACILITY WHERE PATIENT RECEIVES CARE

TELEPHONE NUMBER 1 *(Include area code)*	TELEPHONE NUMBER 2 *(Include area code)*	HEIGHT *(inches)*	WEIGHT *(pounds)*	PULSE	BLOOD PRESSURE
					/

IS PATIENT ALLERGIC TO ANYTHING? *(Please include food allergies) (If Yes, specify)* ☐ YES ☐ NO _____

DOES PATIENT EXPERIENCE ANY ALLERGIC REACTION TO MEDICATIONS? *(If Yes, specify medications)* ☐ YES ☐ NO _____

LIST **ALL** MEDICAL DIAGNOSES *(If more room is needed, please attach a problem list)*

1. _____ 2. _____

3. _____ 4. _____

DOES THE PATIENT HAVE ANY PHYSICAL LIMITATIONS? ☐ YES ☐ NO

DOES THE PATIENT USE A WHEELCHAIR? ☐ YES ☐ NO

IS IT A MOTORIZED WHEELCHAIR? ☐ YES ☐ NO

DOES PATIENT USE WHEELCHAIR MAJORITY OF THE TIME? *(If Yes, under what circumstances?)* ☐ YES ☐ NO _____

OXYGEN REQUIRED? *(If Yes,check appropriate box)* ☐ YES ☐ NO ☐ ALL THE TIME ☐ AT NIGHT ONLY ☐ PRN

NEBULIZER NEEDED? ☐ YES ☐ NO

CPAP USED? ☐ YES ☐ NO *(If Yes, is CPAP with 02?)* ☐ YES ☐ NO

LIST CURRENT MEDICATIONS, DOSAGE, AND HOW OFTEN ADMINISTERED *(May attach Health Summary that includes all current medications)*

MEDICATION:	DOSAGE:	ADMINISTRATIONS:

SELF MEDICATED? ***(If No, patient MUST be accompanied by an attendant!)*** ☐ YES ☐ NO

ANY SPECIAL ASSISTANCE REQUIRED IN ACTIVITIES OF DAILY LIVING?

LIST ANY SPECIAL ASSISTIVE EQUIPMENT PATIENT WILL NEED TO BRING WITH THEM

PATIENT REQUIRES AN ATTENDANT TO ATTEND THE

FESTIVAL IN _____ ? ☐ YES ☐ NO _____

(If Yes, attendant's name)

In the examining clinician's opinion, the above individual

☐ **IS** CLEARED TO ATTEND ☐ **IS NOT** CLEARED TO ATTEND

SIGNATURE AND TITLE OF EXAMINING CLINICIAN	NAME AND ADDRESS OF EXAMINING CLINICIAN *(Please print)*
DATE	TELEPHONE NUMBER