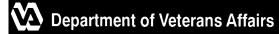
OMB Number: Respondent Burden: 20 minutes



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.

complete this application will forms.	average 20 minutes. This incl	ludes the ti	me it will tal	ke to	read instructions, gathe	er the necessary facts	and fill out the	
*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				AL SECURITY BER (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 PRESSUR	RE	
						_		
IS PATIENT ALLERGIC TO AN' (Please include food allergies) (If Y		YES	NO					
DOES PATIENT EXPERIENCE ANY ALLERGIC REACTION TO MEDICATIONS? (If Yes, specify medications)								
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 N	IIGHT ONLYF	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:		_ DOSAG	iE:		ADMINISTRAT	IONS:		
MEDICATION:		DOSAGE:		ADMINISTRATIONS:				
MEDICATION:		DOSAGE:		ADMINISTRATIONS:				
MEDICATION:		DOSAGE:		ADMINISTRATIONS:				
MEDICATION:		DOSAGE:		ADMINISTRATIONS:				

SELF MEDICATED? (If No, patient MUST be accompanied by an attendant!)						
ANY SPECIAL ASSISTANCE REQUIRED IN ACTIVITIES OF DAILY LIVING?						
LIST ANY SPECIAL ASSISTIVE EQUIPMENT PATIENT WILL NEED TO BRING WITH THEM						
EIGT ANT OF EGIAL AGGISTIVE EQUIT MENT ATTENT WILL NEED TO BINING WITH THEM						
PATIENT REQUIRES AN ATTENDANT TO ATTEND THE						
FESTIVAL IN						
(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					