



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 35 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 _____. Be aware that the elevation in Reno, NV is about 4,505 feet above sea level. 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 <i>(Last 4 digits only)</i>		DATE OF BIRTH	
PATIENT'S ADDRESS <i>(City, State and Zip Code)</i>				VA MEDICAL FACILITY WHERE PATIENT RECEIVES CARE			
CELL PHONE NUMBER <i>(Include area code)</i>	TELEPHONE NUMBER 2 <i>(Include area code)</i>	HEIGHT <i>(inches)</i>	WEIGHT <i>(pounds)</i>	PULSE	BLOOD PRESSURE _____ / _____		

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

DOES PATIENT EXPERIENCE ANY ALLERGIC REACTION TO MEDICATIONS? YES NO _____
(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 NIGHT ONLY PRN

NEBULIZER NEEDED? YES NO

CPAP USED? YES NO *(If Yes, is CPAP with O2?)* YES NO

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

MEDICATION: _____	DOSAGE: _____	ADMINISTRATIONS: _____
MEDICATION: _____	DOSAGE: _____	ADMINISTRATIONS: _____
MEDICATION: _____	DOSAGE: _____	ADMINISTRATIONS: _____
MEDICATION: _____	DOSAGE: _____	ADMINISTRATIONS: _____
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

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

**RETURN ALL COMPLETED FORMS BY _____
TO:**

Stephanie Torian
Host Site Coordinator (05/Vol)
VA Sierra Nevada Health Care System
975 Kirman Avenue
Reno, NV 89502
Phone: (775) 328-1411 / **Fax:** (775) 337-2276
Stephanie.Torian@va.gov