NEHSA Physician's Statement 2017/2018

This form must be completed by a licensed physician. If participant has seizures, this form can be completed by a neurologist. Please note if this form is not on file or provided to NEHSA prior to the participant taking part in NEHSA activities, they will not be eligible to participate with us.

Participant's Name: _____Date of Birth_____

Is followed by me regularly and is able to participate in adaptive sports and recreation at New England Handicapped Sports Association.

What is the nature of the participant's disability? _____

Does the participant have allergies? YES ☐ NO ☐ If YES, please list: _____

Does the participant have seizures? YES ☐ NO ☐ If YES, date of last seizure: _____

If YES, type of seizure: _____

Are there specific triggers for their seizures: _____

_____

Does the participant take medications? YES ☐ NO ☐ If YES, please list along with dosages and purpose of medications. _____

_____

Please provide any other details regarding the participant that we should know about particularly with concerns during adaptive sports and recreation, including downhill and cross country skiing, snowboarding, kayaking, rowing and cycling.

_____

_____

_____

Physician – Please Print: _____

Signature: _____ Date: _____

Address: _____

Telephone Number: _____

Please return this form to:

New England Handicapped Sports Association
PO Box 2135 ● Newbury, NH 03255
Questions call: 603-763-9158 ● Fax: 603-763-4400
info@nehsa.org