

Medical History Self-Report



For applicants to the Riverview Friends Together program.

Instructions

Please complete this medical history questionnaire. Your information is confidential and will be used only to assess your health and readiness to participate in the program. Read each question carefully and answer as accurately as possible. Submit the completed form, along with all other application materials, to Riverview Friends Together. If you have any questions, email friendstogether@riverviewschool.org

Applicant Information

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Residential Address

City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Mailing Address (if different from Residential Address)

City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of Applicant	Date
<input type="text"/>	<input type="text"/>

Primary Contact Information

First Name	Last Name
<input type="text"/>	<input type="text"/>

Relationship to Applicant

Phone Number

Email Address

Secondary Contact Information

First Name	Last Name
<input type="text"/>	<input type="text"/>

Relationship to Applicant

Phone Number

Email Address

Riverview Friends Together reaffirms its policy of equal opportunity and does not discriminate against any applicant on the basis of race, color, sex, age, national origin, religion, sexual orientation, gender identity, veteran status, disability or any other category protected by federal, state or local law.

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For applicants to the Riverview Friends Together program.

1. Please provide a brief description of your medical history, including any disability diagnoses that you may have.

2. Please share any additional medical or health-related information that would help us understand how to best support your participation in Friends Together.

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3. Please list any current medications and describe what each medication is used for.

4. Are you able to self-administer your own prescription medications?

Yes

No

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5. Do you currently receive private therapeutic services, such as physical therapy, occupational therapy, psychiatry, speech therapy, or counseling? If so, please indicate which services.

6. Are you able to manage your own personal care needs (such as toileting and basic hygiene) independently? Please provide additional information below if necessary.

Yes

No

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7. Please share any additional medical or health-related information that would help us understand how to best support your participation in Friends Together.