AllPlay Medical Summary
Parent Form

Preferred name or nickname:

Full Name:

Age:

Parents Name:

Contact Phone 1:

Contact Phone 2:

My child visits the following doctors for treatment for: (e.g. Dr John - Asthma)

Current medications:

Does he/she have an asthma plan?	No ☐	Yes ☐	*Please attach this plan*
Does he/she have severe allergies?	No ☐	Yes ☐	*Please attach your allergy plan*
Does she/he have epilepsy or seizures?	No ☐	Yes ☐	*Attach any notes about emergency treatment*

All about strength and balance

Things that help my mobility (crutches, orthoses, chairs):

I can hold a tennis ball	No ☐	Yes ☐	I can hold a full 1 litre bottle	No ☐	Yes ☐
I can hold something over my head	No ☐	Yes ☐	I can move about without falling	No ☐	Yes ☐
I can run without falling	No ☐	Yes ☐	I can kick a soccer ball?	No ☐	Yes ☐
I can stand up from sitting on the floor	No ☐	Yes ☐	I tend to move slowly	No ☐	Yes ☐
I find it difficult to be still	No ☐	Yes ☐	I tend to bump into things and people	No ☐	Yes ☐
I can close my eyes and stand upright	No ☐	Yes ☐			

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All about endurance

I can sit for 30 minutes No ☐ Yes ☐

I can move around the house on my own No ☐ Yes ☐

I can jump on a trampoline for minutes

I can run without getting puffed for minutes or distance

I can walk around the school oval without getting puffed, wheezy or dizzy No ☐ Yes ☐

List the things that may affect endurance such as medication, heart disease or asthma? If so, how do they impact?

All about co-ordination and flexibility

I can touch my knees No ☐ Yes ☐

I can catch a beach ball No ☐ Yes ☐

I can walk on a straight line No ☐ Yes ☐

My joints are more flexible than other people's. No ☐ Yes ☐

I can touch my toes No ☐ Yes ☐

I can catch a tennis ball No ☐ Yes ☐

I can clap or tap to music No ☐ Yes ☐

I can pedal a bicycle with training wheels No ☐ Yes ☐

I can pedal a bicycle without training wheels No ☐ Yes ☐

All about vision and hearing

Do you wear glasses? No ☐ Yes ☐

I can see a large bright object No ☐ Yes ☐

I can see a tennis ball on the other side of a the room No ☐ Yes ☐

Do you wear a hearing aid? No ☐ Yes ☐

Do you use signing? No ☐ Yes ☐

I can hear when my name is called No ☐ Yes ☐

I usually look at people when they speak No ☐ Yes ☐

I get confused when there are too many noises or voices No ☐ Yes ☐

I wear them in these circumstances:

I can see a person on the other side of a school oval. No ☐ Yes ☐

or cochlear implant? No ☐ Yes ☐

I can hear a referee whistle. No ☐ Yes ☐

If I am far away No ☐ Yes ☐

I am sensitive to noise No ☐ Yes ☐

Other things you would like us to know about your hearing or vision:

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All about understanding and feelings

I can understand requests such as "sit down", "come here" No ☐ Yes ☐

I can understand and follow when I asked to do 3 things in a row No ☐ Yes ☐

I can remember things I was asked to do last week No ☐ Yes ☐

I move quickly from one thing to another No ☐ Yes ☐

I learn best by being shown a task No ☐ Yes ☐

I will persist with a task until I get things right No ☐ Yes ☐

I usually have enough energy to do things No ☐ Yes ☐

I like things to be perfect No ☐ Yes ☐

I can understand concepts such as "in", "out", "under", "over" No ☐ Yes ☐

I can remember things I am told for half an hour No ☐ Yes ☐

I can wait my turn if asked No ☐ Yes ☐

I look at others when I do not know what to do No ☐ Yes ☐

or by being told how to do things No ☐ Yes ☐

I am happy to try new things No ☐ Yes ☐

I become easily upset No ☐ Yes ☐

I become anxious in certain situations No ☐ Yes ☐

Please describe:

All about communication

I usually talk in single words ☐ short phrases ☐ full sentences ☐ signs ☐

I find it easy to explain what I need No ☐ Yes ☐

I am good at asking for help from adults No ☐ Yes ☐

I can express my feelings in a stressful situation No ☐ Yes ☐

All about living skills

I can drink from a water bottle on my own No ☐ Yes ☐

I can put on a jacket or vest No ☐ Yes ☐

I sometime needs to go to the toilet quickly No ☐ Yes ☐

I can take off clothes when I am hot No ☐ Yes ☐

I can put on shoes and do up laces No ☐ Yes ☐

Please describe any help you need with toileting:

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All about co-operation and working with others

I like to do things that other children are doing — No ☐ Yes ☐

I can greet or farewell other children — No ☐ Yes ☐

I know not to hurt other children — No ☐ Yes ☐

I need help to join a group — No ☐ Yes ☐

I know how to stay safe by staying with other people — No ☐ Yes ☐

I prefer to play with other children than play alone — No ☐ Yes ☐

I can follow what others are doing — No ☐ Yes ☐

I become upset if others are yelling — No ☐ Yes ☐

I know when other people need help and how to get help for them — No ☐ Yes ☐

All about personal preferences

I like repetitive activities — No ☐ Yes ☐

I prefer to play with boys ☐ girls ☐ either ☐

I am uncomfortable in /distressed by some situations — No ☐ Yes ☐

Please describe:

I prefer routines — No ☐ Yes ☐

I have particular preferences in clothes/costumes: — No ☐ Yes ☐

Please describe:

Things that motivate me or make me happy are:

AllPlay Medical Summary
Doctor Form

Preferred name or nickname:

Full Name:

Age:

Parents Name:

Contact Phone 1:

Contact Phone 2:

Doctors Name:

Doctors Phone:

This child is receiving treatment for:

Current medications:

Does he/she have an asthma plan?	No ☐	Yes ☐	*Please attach this plan*
Does he/she have severe allergies?	No ☐	Yes ☐	*Please attach your allergy plan*
Does she/he have epilepsy or seizures?	No ☐	Yes ☐	*Attach any notes about emergency treatment*

Doctor's Recommendations: (Please use back of form if insufficient space)

Support needed with motor skills and endurance: No ☐ Yes ☐

Describe specific issues e.g. lower limb movement, co-ordination/balance, fatiguability and need for rest, joint instability:

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Support needed for hearing/vision/sensory: No ☐ Yes ☐

Describe specific issues: e.g. need for signing, visual aids, hearing aids, non-touch sports, low noise levels:

Emotional support needed: No ☐ Yes ☐

Describe specific issues: e.g. anxiety about change, reassurance about abilities, mood, calming strategies:

Support needed for social inclusion and understanding: No ☐ Yes ☐

Describe specific issues: e.g. following instructions, need for extra practise or repetition, self-care skills, social routines, understanding of others :

Activities that must be avoided e.g. contact sport for neck instability:

Doctors Name:

Signature:

Date: