FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS *(Authorization by patient or parent/guardian included on Page 1 of this form)*

1. FOR CHILDREN UNDER AGE 6 ONLY

a. IF PATIENT IS LESS THAN 12 MONTHS OLD, WAS IT A PREMATURE BIRTH? *(X one)*

☐ YES ☐ NO

b. DATE OF LAST WELL-CHILD EXAMINATION *(YYYYMMDD)*

c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? *(X one. If No, please explain.)*

☐ YES ☐ NO

2. TEMPORARY CONDITIONS THAT MAY IMPACT TRAVEL CONSIDERATIONS IN THE NEXT YEAR

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES

d. TIME FRAME *(Explain anticipated duration of temporary condition and identify any limitations for activities of daily living and travel limitations.)*

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV Use item 11 (Comments) if more space is needed.

a. ACTIVE DIAGNOSIS REQUIRING CARE WITHIN LAST YEAR *(If Asthma, Cancer or Mental Health within last 5 years)*	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES *(Also annotate rare or special consideration medications used within specified time period)*	d. COMPLETE FOR THE LAST 12 MONTHS:
If Asthma or RAD is noted, also complete Asthma Addendum 1. If Mental Health is noted, to include Attention Deficit Disorders, also complete Mental Health Addendum 2. If Autism Spectrum Disorder(ASD)/Developmental Delay (DD) is noted, also complete Addendum 3.			
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
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