

Wisconsin Academy for Graduate Service Dogs

1337 Greenway Cross, #157
Madison WI 53713
608-250-9247

Medical History Form

To the Physician: Please complete this form and return it to the Wisconsin Academy for Graduate Service Dogs (WAGS). This form is needed to complete your patient’s application for a WAGS Service Dog. The information provided will help WAGS determine the applicant’s suitability for a service dog, and to plan a training program that takes into consideration the applicant’s medical conditions. All medical information about the applicant will be kept strictly confidential.

Physician Information

Name: _____

Address: _____

Phone: _____

Applicant Information

1. Applicant’s Name: _____

2. What is the applicant’s primary disability?

What is the prognosis of the disability?

3. Please list any secondary disabilities:

4. Does the applicant’s disability affect their cognitive abilities or functioning in any capacity?

Yes / No *If yes, please describe*

5. Does the applicant have a history of seizures? Yes / No

6. Do you have any concerns about the applicant’s ability to physically tolerate the training required to work with a service dog? Yes / No *If yes, please describe:*

7. Do you have any concerns about the applicant's ability to cognitively participate in the training? Yes / No *If yes, please describe:*

8. Do you have any concerns about the applicant's ability to care for a service dog? Yes / No *If yes, please describe:*

9. Why do you feel the applicant would benefit from having a service dog?

10. Are there any additional comments you wish to make that might help us in evaluating your patient's application for a service dog?

Your Signature _____ Date _____

** Thank you **