Adult Day Care
Medical Examination Report

Name: _____ Birthdate: _____

Address: _____

Date last examined by a doctor: _____

The above named individual has applied for enrollment at Blessed Assurance Adult Day and Health Care Center. Your careful examination and written recommendations on this form will help to ensure that the applicant is provided appropriate care and services, will encourage safe participation in Adult Day Care Activities and will provide a current medical history in case of an emergency.

Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

1. Applicants History and Physical:

Current Diseases/ Chronic Conditions	Yes	Special Attention	Restrictions
Anemia	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Blindness	_____	_____	_____
Cerebral Palsy	_____	_____	_____
Diabetes	_____	_____	_____
Dementia/Alzheimer's/Parkinson's	_____	_____	_____
Effects of Stroke/Paralysis	_____	_____	_____
Emphysema/Chronic Bronchitis	_____	_____	_____
Epilepsy	_____	_____	_____
Fainting Spells	_____	_____	_____
Gastro-intestinal Problems	_____	_____	_____
Heart Trouble	_____	_____	_____
Hearing Problems	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Mental Retardation	_____	_____	_____
Skin Disorder	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers	_____	_____	_____
Urinary Tract Problems	_____	_____	_____

Vitals: Temp: _____Pulse: _____ Resp: _____ BP: _____ Weight: _____ Height: _____

Any other disease(s) or condition(s) not mentioned above?

_____
_____
_____

Any allergies or drug and food interaction problems? _____
_____

Currently receiving any medical treatment(s)? No _____ Yes _____
If Yes, please explain: _____
_____

2. Professional Opinions and Recommendations:

Does this person have any psychiatric problems? No _____ Yes _____
If Yes, please comment on the nature, severity and treatment needs: _____
_____
_____

Does this person require constant supervision to ensure he/she does not harm themselves, others or property? No _____ Yes _____

Will this person wander off if not closely monitored? No _____ Yes _____

Do you recommend any restrictions for medical reasons, on physical activities such as walking, exercises, etc.? No _____ Yes _____
If Yes, please explain: _____
_____

Describe any Physical, Occupational, Speech or any other Therapy needed: _____
_____
_____

****Please list all medications currently taken, prescribed routes, dosages, frequency and amount:**
_____
_____
_____

****May the nurse at this center administer these medication(s) to the patient?** No _____ Yes _____

Please list any special diet and dietary supplements: _____
_____

Is this individual free of communicable diseases? No _____ Yes _____
If No, please specify: _____
_____

3. Immunizations:

Date/Results: PPD _____ 2nd PPD _____ Chest X-Ray _____ Tetanus _____
Any others _____ History of Hepatitis A, B, C, D _____ MRSA _____

****May the Nurse at this center administer the PPD skin test to the patient?** No _____ Yes _____

I certify that I have reviewed the health history and examined this person and find him/her free of communicable diseases and able to participate in this Adult Day and Health Care Program.

****This Information is required due to regulation changes****

Sign and Print: _____ Date: _____
(Licensed Physician or PA)

Address: _____ City: _____ Phone: _____