Adult Day Care Medical Examination Report

Name: _____ DOB: _____

Address: _____

Date last examined by a physician: _____

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 us to ensure that the applicant is provided appropriate care and services, will encourage safe participation in Adult Day Care, 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 permission.

1. Applicant's History & Physical: (Circle applicable conditions and note any special attention/details/types/restrictions. **Please be as specific as possible.)**

Anemia_____

Arthritis_____

Vision Conditions_____

Cerebral Palsy_____

Diabetes_____

Dementia/Alzheimer's _____

Effects of stroke/paralysis_____

Respiratory Conditions_____

Epilesy_____

GI problems_____

Heart Trouble _____

Hearing Conditions_____

High Blood Pressure_____

Kidney Disease_____

Intellectual Disability_____

Parkinson's _____

Skin Disorder_____

Tuberculosis_____

Ulcers_____

If there are any other diseases/conditions that are not mentioned above, please list them here:

_____

Vitals: Temp:_____Pulse:_____Resp:_____BP:_____Weight:_____Height:_____

Allergies or food/drug interaction problems: _____

Currently receiving any medical treatment(s)? Yes No

If yes, please explain: _____

Does the patient have any implants? _____

2. Professional Opinions and Recommendations:

Does this person have any psychiatric issues? Yes No

If so, please comment on the nature, severity, and treatment needs: _____

_____

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

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

Any exercise restrictions? Yes No If yes, explain: _____

_____

Is this person receiving any type of therapy such as speech, physical, or occupational? Yes No

If yes, please explain: _____

Check this box to ensure that a current medication list is attached! ☐

Please list any special diet/dietary supplements: _____

3. Immunizations

Is this person free of any communicable diseases? Yes No

If no, explain _____

Date/Result of most recent:

PPD: _____ 2nd PPD: _____ Chest X-Ray: _____ Tetanus: _____

Any others: _____ Any history of Hep. A, B, C, D? Yes No | MRSA? Yes No

By signing, I certify that:

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

2. The nurse may administer these medications to the patient as necessary.

3. The nurse may administer a PPD skin test to this patient as necessary.

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

Address: _____ City: _____ Phone #: _____