SARA'S PLACE ADULT DAY SERVICES

MEDICAL EXAMINATION REPORT Page -1-

Name: _____ Birthdate: _____

Address: _____

Most recent date seen by a doctor: _____

The above named person has applied for enrollment in our adult day care program at:
SARA'S PLACE
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 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. Does the applicant have any of the following diseases or conditions? If so, please indicate whether or not the condition requires any special attention or restricts normal activities.

Current Disease/ Chronic Condition	Yes	Special attention required	Restrictions on activities
Anemia			
Arthritis			
Asthma			
Blindness			
Cerebral Palsy			
Diabetes			
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 Disorders			
Ulcers			
Urinary Tract Problems			

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MEDICAL EXAMINATION REPORT Page -2-

Does this person have any psychiatric problems? Yes [ ] No [ ]

If yes please comment on nature, severity and treatment needs.

_____
_____

Does this person require constant supervision to make sure he/she does not do harm to self, others, or property? Yes [ ] No [ ]

Will this person wander off if not closely attended? Yes [ ] No [ ]

Do you recommend any restriction for medical reasons on physical activities such as walking, exercises, Etc.? Yes [ ] No [ ] If yes, please specify: _____
_____

Please list all medications the person is now taking, with dosages and times medications are to be taken:

_____
_____
_____
_____
_____
_____

Regular Diet? Yes [ ] No [ ] if no, please describe or attach a copy of any dietary restrictions.

_____
_____

Any other comments? _____
_____
_____

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MEDICAL EXAMINATION REPORT Page -3-

I certify that I have today reviewed the health history and examined this person and find him/her physically able to participate in adult day activity programs and is free of communicable diseases.

Signed: _____ Date: _____
(Licensed Physician of Physician Assistant)

Address: _____

Telephone: _____

TB Test Results: _____ Date: _____
To be done annually

Or Chest X-ray: Results: _____ Date: _____