

411 N. Cameron St.  
Suite 100  
Winchester, VA 22601

[adultcare@ntelos.net](mailto:adultcare@ntelos.net)  
[www.adultcarecenter.net](http://www.adultcarecenter.net)



Office Phone  
(540) 722-2273

Fax Phone  
(540) 450-2263

## REPORT OF PARTICIPANT PHYSICAL EXAMINATION

Examination is to be completed by or under the direction of a licensed physician within 30 days prior admission. Report is to be kept as part of the participant's permanent record. **ALL FIELDS MUST BE FILLED OUT BY HEALTH CARE PROVIDER.**

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NAME	DATE OF BIRTH	DATE OF PHYSICAL EXAMINATION
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ADDRESS

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TELEPHONE

Diagnoses and significant problems:

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General physical condition, including a systems review as medically indicated:

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Special diet or any food intolerances:

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ADULT CARE CENTER OF THE NORTHERN SHENANDOAH VALLEY, INC.

**HONORARY BOARD MEMBERS**

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Allergies – (food, medicine, animal or other), and **reaction**:

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Therapy, treatments or procedures participant is undergoing or should receive, and by whom:

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Restrictions or limitations on activities or program participation:

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Medications (Including dosages, route, and frequency of administration):

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Is this person:

Capable of administering his own medications without assistance?     yes     no

Not capable of administering his own medications without assistance?     yes     no

Is this person ambulatory?     yes     no

Is this person:

Physically and mentally capable of self-preservation by being able to respond to an emergency, either to an area of safe refuge area or from the building, without the assistance of another person, even if he may require the assistance of a wheelchair, walker, cane prosthetic device, or a single verbal command.

\_\_\_\_\_yes          \_\_\_\_\_no

By reason of physical or mental impairment is not capable of self-preservation without the assistance of another person.

\_\_\_\_\_yes          \_\_\_\_\_no

Is this person capable of understanding his/her rights?          \_\_\_\_\_yes          \_\_\_\_\_no

**Acetaminophen Administration:**

Permission is given to administer acetaminophen:          \_\_\_\_\_yes          \_\_\_\_\_no

If yes, please answer the following five sections:

Symptoms that indicate use of this medication:

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Medication dosage (note: must be exactly specified; for example, 'two 325 tab' instead of 1-2 tabs)

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Times the medication is to be given in a 24-hour period (note: must be exactly specified; for example, 'q 4 hours prn' instead of q 4-6 hours prn') \_\_\_\_\_

Directions if symptoms persist:

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Any additional instructions: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Please print or type physician's name here)

Address (Street, City, State, Zip Code)

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Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_