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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.**

NAME	DATE OF BIRTH	DATE OF PHYSICAL EXAMINATION
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ADDRESS

TELEPHONE

Diagnoses and significant problems:

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

Height: _____ Weight: _____ Blood pressure: _____

Diet: Please Be Specific (such as Regular, No Added Sugar, No Added Salt) and any food intolerances: (such as No Nuts or No Seeds)

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

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

Restrictions or limitations on activities or program participation:

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

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:

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

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:**

Any additional instructions:_____

Signature:_____ Date:_____

(Please print or type physician's name here)

Address (Street, City, State, Zip Code)

Telephone:_____ Fax: _____