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Adult Care Center
of the NSV, Inc.
Encouraging, engaging, & enriching since 1993

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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

_____

ADDRESS

_____

TELEPHONE

Diagnoses and significant problems:

_____

_____

_____

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

_____

Height: Weight: Blood pressure: _____

Diet: Please Be Specific & Check

- ○ Regular
- ○ No Added Sugar
- ○ No Added Salt

Food intolerances:

- ○ No Nuts
- ○ No Seeds
- ○ Other Intolerances

_____

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: _____