

Coconut Grove Adult Day Care Center Participant's Health Assessment

Patient's Name: _____

Date of Birth: ____/____/____ Age: ____ Height: ____ Weight: ____ lbs. Gender: Male Female

1. Medical History & Diagnoses: _____

2. Allergies: _____ OR No Known Allergies

3. Physical or Sensory Limitations: _____

4. Cognitive or Behavioral Status: _____

5. Should the participant be restricted for any medical reasons from performing any activities at the Adult Day Care Center, such as walking, exercise, etc.? NO YES (Specify): _____

6. Any psychiatric history? NO YES (Specify): _____

7. IS PATIENT FREE OF COMMUNICABLE DISEASES?

YES – This patient is FREE from Tuberculosis in a communicable form and apparent signs and symptoms of other communicable diseases, and does not constitute a risk of communicating disease to any person under the care of the Center.

NO (Specify): _____

8. Is participant able to self-administer his/her medication while at the Adult Day Care Center? YES NO

9. Special Diet Instructions: Regular Diabetic Diet No Salt Added Low Salt Low Fat / Low Cholesterol

Other special diet instructions: _____

10. Please list all current medications, including dosage and time medication is to be taken **OR** See attached medications list

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Physician's Attestation: I certify that I have reviewed the health assessment and examined this person on _____ and find him/her physically able to participate in the Adult Day Care Center. Date of Examination

Physician's Name: _____ Signature: _____ Date: _____

Medical License #: _____ Tel#: _____ Fax#: _____

Physician's Address: _____
Street Address City State Zip