TRINITY LIVING CENTER
(704) 637-3940 phone (704) 637-6929 fax

Medical Examination Report

Name: _____ Birthdate: _____

Address: _____

The above named person has applied for enrollment at Trinity Living Center, an adult day care/day health program. 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 service activities and will provide a current medical history in case of emergency.

Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

I. 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	Restriction on Activities
Anemia			
Arthritis			
Asthma			
Blindness			
Cerebral Palsy			
Dementia			
Diabetes			
Effects of Stroke/Paralysis			
Emphysema/Chronic Bronchitis			
Epilepsy			
Fainting Spells			
Gastrointestinal Problems			
Heart Problems			
Hearing Problems			
High Blood Pressure			
Kidney Disease			
Mentally Challenged			
Skin Disorders			
Tuberculosis			
Ulcers			
Urinary Tract Problems			

Any other disease or condition not mentioned above: _____

_____

Any allergies or reactions to medications: _____

_____

Most Recent Date Seen by Physician (including this visit): _____

Vital signs at this exam: BP_____ Pulse _____ Respirations _____ Wt _____

II. Does this person have any psychiatric problems? ☐ No ☐ Yes -- If yes, please state 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? ☐ No ☐ Yes

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

III. Do you recommend any restrictions on physical activities?

☐ No ☐ Yes If yes, please specify:

_____

IV. Please list all current medications with dosages and times medications are taken:

Name of Medication	**Dosage**	**Time(s) Taken**

V. Any special diet? ☐ No ☐ Yes -- If yes, please describe: _____

_____

VI. Any other comments: _____

_____

_____

I certify that I have reviewed the health history and examined this person and find him/her physically able to participate in an adult day service program.

MD, PA or NP Signature: _____ Date: _____

Address: _____ Phone: _____