BROWARD ADULT DAY CARE CENTER

2615 Davie Blvd. Fort Lauderdale, Florida 33312

Phone: 954.7911611 FAX: 954.688.2552

PARTICIPANT'S HEALTH ASSESSMENT

Name:_____________________________ DOB:________________

Known Allergies:_________________

Height ____________ Weight _____________

Medical history and diagnoses:____

____

Physical or sensory limitations:____

____

Cognitive or behavioral Status:

Any contagious disease(s): Yes ________ No ________

Date of X-ray: _______________ or Date Tuberculin Test given:___________

Result of Chest X-ray: _______ or result TB test:___________________

(Free from tuberculosis and other communicable diseases)

Is a participant able to self-administer the medication while at the Adult Day Care ?

YES _______ or NO ___________

Does the participant have any psychiatric history?

YES___or NO___ If Yes please comment:______________________________

Should the participant be restricted for medical reasons, from performing any activities at the Adult Day Care Center (walking,exercise etc.)?

YES.__________ or NO __________

If yes specify:____

SPECIAL DIET INSTRUCTIONS?

_________REGULAR __________DIABETIC DIET
_________NO ADDED SALT __________LOW FAT LOW CHOLESTEROL

ADULT DAY CARE provided breakfast, lunch and snacks. The Food is a regular diet and contains a minimal of salt low cholesterol and low fat.

Please list all current medications including dosage and time medication is to be taken.
1________________________________
2________________________________
3________________________________
4________________________________
5________________________________
6________________________________

I certify that I have reviewed the health assessment and examined this person and find him/her physically able to participate in the **Adult Day Care Center**.

DATE OF EXAMINATION: _________________________

SIGNATURE OF PHYSICIAN: _______________________

NAME OF THE PHYSICIAN (PRINT): ___________________________________

MEDICAL LICENSE#: __________________________
ADDRESS OF PHYSICIAN:. ____

Telefone: ________________

Broward Adult Day Care:

Prescription Medication List

Participant Name: ____

This form must be completed by the participant's physician, no more than 45 days prior to admission, and is required to be updated as changes are made. No changes will be made, unless the participant, physician, guardian, or responsible person provides a· signed statement that the medication may be taken as ordered by the prescribing physician.

Prescription Name:	Dosage:	Schedule:

Physician Signature ____________ Print Name ___________________ Date _________

Broward Adult Day Care:

Freedom from Communicable Diseases

Date:

____

The purpose of this statement is to certify that________________________________ is free from tuberculosis in the communicable form and documenting freedom from signs and symptoms of other communicable diseases.

Physician Signature __________________ Date___________

Print Name __________________________ Date___________