Medical Examination Report

Name _____ Date of Birth _____

Address _____

Most Recent Date of Medical Exam _____

The above-named individual has applied for enrollment at the Senior Circle of Friends ADC. Your careful examination and written recommendations on this form will help ensure that the applicant is provided appropriate care and services, will encourage safe participation in adult day center activities and will provide a current medical history in case of an emergency. Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

I authorize the release of this information to the Senior Circle of Friends ADC to be placed in the participant record to the above-named person.

Signature _____ Date _____

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List the person's current disease/chronic condition/medical diagnosis _____

_____

_____

Is the person free of communicable diseases? _____

Allergies of reactions to any medicine _____

Receiving any medical treatments: If so, explain. _____

_____

_____

List any special attention required. _____

_____

_____

Does this person have any psychiatric problems? Yes ____ No ____

If yes, please comment on the nature, severity, and treatment needed: _____

_____

_____