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❒ Gracious Living (Huntersville)
16630 Northcross Drive, Suite A
Huntersville, NC 28078

❒ Gracious Living (South Charlotte)
7950 Nations Ford Road
Charlotte, NC 28217

❒ Gracious Living (Pineville)
10635 Park Rd Medical Office Building
Charlotte, NC 28210

MEDICAL EXAMINATION REPORT

PARTICIPANT'S NAME _____ DATE OF BIRTH _____

Address _____

Most recent date seen by Doctor _____

The above named person has applied for enrollment in Gracious Living Adult Day Health Care Center, Corporation. 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 care activities and will provide a current medical history in case of an emergency. Information on this form is considered confidential and will be released only with the applicant's written authorization._____

1. 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, Please Specify	Special Attention Required	Restriction on Activities
Anemia			
Alzheimer's Disease/ Level of Alzheimer's (Please circle one) 1 2 3 4 5			
Arthritis			
Cardiac Problems			
Diabetes			
Epilepsy/Seizures/Fainting			
Gastrointestinal Problem			
Hearing Problem			
Hypertension			
Kidney/Urinary Problem			
Mental Retardation			
Multiple Sclerosis			
Neurological Problem			
Respiratory Problem			
Skin Disorder			
Effects of Stroke			
Visual Problem			

Participant's Name: _____

Please describe any other disease or condition not mentioned above: _____

Receiving any medical treatments? If so, explain _____

Past surgery or recent hospitalizations _____

Which hospital is preferred for this person? _____

2. Does this person have any psychiatric problems? Yes_____No _____ If yes, please comment on nature, severity and treatment needs: _____

_____

_____

Does this person require constant supervision to make he/she does not do harm to self, others or property? Yes____ No____.

Will this person wander off if not closely attended? Yes____No _____

3. Do you recommend any restrictions for medical reasons on physical activities such as walking, exercises, etc.? Yes __ No __ . If yes, please specify: _____

4. Please list all medications the person is now taking, with dosages and times medications are to be taken:

Medication	Dosage	Time to be taken

Any allergies or reactions to medication? _____

5. Dietorder: _____

_____

6. Vital Signs: BIP _____Pulse _____ Resp _____ Temp _____

7. Height, _____Weight, _____

Participant's Name_____

PPD Skin Test: Placed (date) _____ Result: _____ (mm) Date read: _____

Important Note: Results ofPPD test must be recorded on this form before the person can be admitted to or remain in our program. If the person is unable to receive PPD test, a report of a recent Chest X-ray noting the lack of evidence of tuberculosis is acceptable.

8. Any other comments:

9. Standing Orders:

I give permission for the following to be administered by the nurse in accordance with state standards:

- Acetaminophen 500 mg one or two tablets orally q 4-6 hours PRN for pain or temperature above
100 degrees.
- May treat superficial skin wounds with Hydrogen peroxide & application of 1) inclusive transparent dressing, or 2) Antibiotic ointment with sterile dressing. Check daily, change PRN and notify doctor of infection.
- PPD 0.1 ml intradermal injection to be given annually and read by nurse. Positive results will be reported to doctor and chest x-ray ordered.

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

Signed _____Date _____
(Licensed Physician, Physician Assistant, or Family Nurse Practioner)

Name _____
(Print name of person who signed above)

Address _____ City/State _____

Telephone _____Fax _____