Granville HEALTH SYSTEM
Quality Care...Close To Home

HAROLD SHERMAN ADULT DAY CENTER
APPLICANT MEDICAL INFORMATION

The individual listed below desires or has enrolled in a Day Program for Adults. Supervision is provided during the day for disabled and elderly adults in a protective setting to promote social, physical and emotional well-being; personal care and to offer opportunities for companionship, self-education and other leisure time activities. The **Harold Sherman Adult Day Center** has been approved by the State Department of Health and Human Resources, Division of Aging and Adult Services to provide these services. In order to protect both the applicant and other participants, it is necessary that we have medical information on each person. This information will also assist the Day Activity personnel in working with this person.

Patient's Name: _____Birth Date: _____

Most Recent Date Seen by a Doctor: TB Test Results [optional]: Positive Negative Date of Test:

Blood Pressure: Pulse/Respiration: Weight:

PHYSICAL HEALTH STATUS:	No	Yes	If Yes, Please Comment
Arthritis, Rheumatism	☐	☐	_____
Asthma	☐	☐	_____
Emphysema, Chronic Bronchitis	☐	☐	_____
Tuberculosis	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Condition	☐	☐	_____
HIV	☐	☐	_____
Circulation Problems	☐	☐	_____
Stomach Ulcers	☐	☐	_____
Diabetes	☐	☐	_____
Gastro-Intestinal Problems	☐	☐	_____
Urinary Tract Problems (include bladder incontinence)	☐	☐	_____
Anemia	☐	☐	_____
Effects of Stroke	☐	☐	_____
Epilepsy	☐	☐	_____
Glandular Disorders	☐	☐	_____
Allergies, Allergic Reactions	☐	☐	_____
Skin Disorders	☐	☐	_____
Communicable Diseases	☐	☐	_____
Cancer	☐	☐	_____
Amputation	☐	☐	_____

Other _____

Primary Diagnosis: _____ Secondary Diagnosis:_____

☐ Malnourishment	☐ Change in Bowel Habits	☐ Shortness of Breath
☐ Lumps	☐ Blood in Urine	☐ Dizziness
☐ Persistent Cough	☐ Hearing	☐ Vision
☐ Severe Headaches	☐ Sudden Weight Loss	☐ Other
☐ Vomiting	☐ Severe Chest Pains	

Medicine Patient is taking for physical health problems (continued on Page 2)

Medicine	Dosage	Frequency

 PATIENT'S NAME: _____

CONTINUED: Medicine Patient is taking for physical health problems

Medicine	Dosage	Frequency

Use additional sheet if necessary

MENTAL HEALTH STATUS:

Organic Brain Damage: ☐ Yes ☐ No Arteriosclerosis: ☐ Yes ☐ No Personality Disorders: ☐ Yes ☐ No

Other:_____

☐ Loss of Appetite
☐ Insomnia
☐ Feeling of Worthlessness
☐ Loss of Interest
☐ Hypochondria
☐ Suspiciousness
☐ Hallucinations
☐ Delusions
☐ Distortion in Thinking
☐ Confusion
☐ Impaired Judgment
☐ Memory Loss
☐ Orientation Problem
☐ Hazardous Behaviors
☐ Alcohol Abuser
☐ Drug Abuser

Medications patient is taking for mental health problems:

Medicine	Dosage	Frequency

GENERAL INFORMATION:

☐ Does this person require constant supervision to make sure harm is not done to self, others or property? Yes No

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

☐ Can this person do light exercises from a sitting position, such as leg lifts, arm lifts, etc? Yes No

☐ Do you recommend any special type of activities for this client, such as group social activities, craft activities, physical exercise, training in self-care? ☐ Yes ☐ No

☐ Has this person had a pneumonia vaccine? ☐ Yes ☐ No Date of vaccine _____ If no, would they benefit from one and can they receive one during this visit? ☐ Yes ☐ No Vaccine received date _____

☐ Is a special diet or other special regimen required for this patient? ☐ No ☐ Yes, if yes please attach or describe:

_____

Please comment on any physical, mental or emotional condition apparent from your knowledge of the above named person that might need further explanation or might affect other participants.

_____

_____

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 activity program.

Signed: _____ Date: _____

M.D., P.A. or Nurse Practitioner

Address: _____ City: _____

Phone: (_____)_____

HAROLD SHERMAN ADULT DAY CENTER MEDICINE LIST/WAIVER

To be prepared for the emergencies that can and do happen, please list below all medications being taken either at the Center or at home by the participant. This will provide the rescue squad with the vital medical information that is necessary to administer proper treatment. It is important that the staff at the Center be given in writing any changes in medication to keep our records current.

I hereby authorize the personnel of **Harold Sherman Adult Day Center** to administer the medicine(s) listed below. In doing so, I hereby release said program, its officers, staff and personnel, from any and all liability that might arise as a result of the medication being administered and hereby waive any action which I may have as a result of the medication being administered. I will be notified when the medicine supply is low. Furthermore, I release the fore said from any and all liability that might arise as a result of said medication not being administered because the supply was not replenished.

Participant's Name: _____

If Taken at the Program	Times Given at Program	Name of Medication	Dosage	Frequency	Route	Notes
		Use back if necessary				

Over-the-counter medication(s) ordered by Physician: (Physician's order with dosage & instructions are required):
_____

Allergies: _____

Medication Policy:

State regulations prohibit administering any medication not in the original container from the doctor or pharmacy. North Carolina Adult Day Care Standards for Certification state that medications kept by the program shall be in containers in which they were dispensed from the pharmacy. The containers shall be clearly labeled with the participant's full name, the name and strength of the medicine, and dosage and instructions for administration. Only medications that meet this stated criterion will be given. Most pharmacies will give two containers if asked. Pills brought to the center in envelopes, pills boxes or other containers not meeting the above description cannot be given. Harold Sherman Adult Day Center requires any over the counter medications be accompanied by a physician's order when dispensed at the program.

With everyone's safety in mind, it is necessary to strictly comply with this policy. It is not intended to be a hardship on anyone. Thank you for your cooperation.

Participant's Signature: _____ Date: _____

Guardian/Medical POA's Signature: _____ Date: _____