



Roitenberg Family Adult Day Center

Participant File

Medical Summary

Individual must be seen by physician and have form completed within 3 months prior to ADC enrollment - If for renewal, must be completed within 3 months of that date. MANTOUX IS REQUIRED FOR BOTH!

Name _____ Date of MD visit _____

Physician's Name _____

Clinic Name & Address _____

Phone () _____ Fax () _____

Does this individual have a Health Care or Financial POA? YES NO

Health History (please include current diagnoses & detailed health history including medical and mental health)

Is individual aware of these diagnoses? YES NO Needs Reminders

Is individual free from communicable disease or infection? YES NO

Medications (please list ALL current PRESCRIPTION AND OVER THE COUNTER medications - mark the box next to those that will be taken at the ADC with an X)

Can this individual take PRN Tylenol for pain? YES NO Dose _____

	MEDICATION	DOSAGE	TIME TAKEN	REASON	SPECIAL INSTRUCTIONS
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Can individual manage own medications? YES NO Needs Observation/Reminders

**Medication Allergies _____

Can individual monitor own allergies? YES NO Needs Reminders

