Coulee Region Adult Day Service
Physician's Report on Health History and Physical

Client Name: _____ Date of Birth: _____

This is to certify that on _____ I performed a physical exam on _____.

On the basis of this examination, it is my finding that the above named person does not have an illness or a medical condition that would endanger the health, safety or welfare of other adult clients and staff within the facility.

Findings: Vital Signs
Ht _____ (in) Wt _____ (lb) B/P _____ Pulse _____ RR _____

Significant findings
_____
_____
_____

List of Diseases and Chronic Conditions:
_____
_____
_____

Does this client have limits to activities? Yes NO
If yes, please list: _____
_____

List any allergies: _____
_____
_____

T.B. test:
Administered Date: _____ Results:_____

Authorization to Control and Administer Medication

To ensure the safety and regulation for all clients attending Coulee Region Adult Day Center we require all medications to be brought to the facility in there original prescription containers and that we have written medication orders from the his/her physician. If the client is able to assist with their medications the facility will maintain the medications in a locked area and deliver or assist with delivery of the medications.

Can the above person take their own medications, prescription and OTC
YES NO
Administered by facility staff YES NO

List of all medications, prescription and OTC with strength, dosage and directions for use as well as any side effect or adverse reactions to be aware of: _____
_____
_____
_____
_____

I authorize non-license staff at Coulee Region Adult Day Center to pass medications to this client.

_____ _____
Physicians/Health Care Providers Signature Date

_____
Physicians/Health Care Provider Name (printed)

_____ _____
Address Phone