Canopy Way Adult Day Care

Annual Physical Report & TB Test

*Please have the following form filled out ***by a Physician, Physician's Assistant or RN.***

Name:____ **Birthdate**:_____________________

Address:____

Date of Last Exam by a Physician: ____

The above-named individual has applied for enrollment or is a current participant requiring their annual P.E. at Canopy Way Adult Day Care. 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 emergency.

Information on this form is considered confidential and will be released only with the applicant's written authorization.

Sincerely,
Kim Kelly-Speranza, Director
Canopy Way Adult Day Care

VITALS

Temp_______ Pulse_______ Resp_______ BP_______ Wgt_______ Hgt______ CODE_______

MEDICAL CONDITIONS/ DISEASES

Anxiety	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Cancer	Yes	No	
Covid-19	Yes	No	Dates: ___________
Dementia/ Alzheimer's	Yes	No	
Depression	Yes	No	
Diabetes, type I or II	Yes	No	
Edema	Yes	No	
Effects of Stroke, weakness, paralysis	Yes	No	
Emphysema/ Chronic Bronchitis	Yes	No	
Fainting Spells	Yes	No	
Gastro-Intestinal Issues	Yes	No	
Hearing difficulties	Yes	No	
Heart	Yes	No	

High Blood Pressure	Yes	No	
Infectious Skin Disorders (Staph, Shingles etc.…)	Yes	No	
Kidney Disease	Yes	No	
Parkinson's	Yes	No	
Pneumonia	Yes	No	
Seizures	Yes	No	
Tuberculosis	Yes	No	
Ulcers	Yes	No	
Urinary Tract Problems	Yes	No	

List of Surgeries with in last 5 years and dates.

Can Participant take any of the following?

Tylenol/ Ibuprofen: Yes / No Ibuprofen______ Tylenol______

IMMUNIZATIONS/ VACCINES

Date/Results: PPD __________/__________ Chest X-ray __________/__________

Covid-19 Vaccine 1st ______/ 2nd ______ Flu Shot _______ Hepatitis A, B or C _________

Any Other Immunizations____

Any other Diseases or conditions not mentioned above? ______________________________________

Allergies (Drug or Food)?____

Dietary Restrictions?____

Is Participant receiving any medical treatments? Yes___ No___ If Yes, please explain nature, severity, and treatment needs.

____

Please list any Medications the Participant is taking.

____

Does Participant have any psychiatric conditions? Yes___ No___ If Yes, please explain the nature of the condition.

____

Physician's Name____

PRINT ***SIGN*** ***DATE***

Participant's Name/Responsible Party

____

PRINT ***SIGN*** ***DATE***

CWADC ONLY: Received By: __________ Date: ___________