Agrace Adult Day Center

Medical Report/Health Statement

To be completed by the client's primary health care provider

Please fax this completed form and attachments to (608) 327-7043.

Client name: _____ Date of birth: _____

Does the client named above have any communicable disease, including Tuberculosis?

YES____ NO____

If yes, indicate which communicable disease: _____

Please indicate the client's:

- Allergies (drug, food and other): _____
- Diet: _____
- Code status: _____
- Restrictions that may limit their ability to participate in activities at the Adult Day Center:

  _____

  _____

Please send the following items with this form:

1. A list of all current diagnoses
2. Current immunization record
3. Proof of recent communicable disease screening: TB test results
4. A list of all prescribed medications including dosage, frequency and route

May the client self-administer medications? YES ____ NO ____

This form needs to be fully completed within 90 days prior to the client's enrollment date. TB test results will need to be completed 90 days prior to enrollment or within 30 days after the enrollment date.

Signature from the primary care provider certifies that all information above in this health statement is correct.

PCP name (please print) _____

PCP Signature _____ Date _____