

## Physician's Medical Assessment

Participant's Name \_\_\_\_\_

State regulations require that a medical assessment of the participant's medical condition, by the participant's physician, be submitted prior to the first day of participation. The physician must sign the medical assessment within five (5) working days of the first day of participation. It must include, at a minimum, the following information (either on this form or on a signed attachment):

- Medical diagnosis \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Activity needs and restrictions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Dietary modifications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Allergies, Medical \_\_\_\_\_
- Allergies, Food \_\_\_\_\_

Participants who are responsible for taking their own medication at home shall be permitted and encouraged to continue to be responsible for taking their own medication.

Is the participant capable of taking medications independently?

\_\_\_ Yes \_\_\_ No Comments \_\_\_\_\_

\_\_\_\_\_

Tiffany's Adult Day Care may not administer medications, including nonprescription medicines, without orders by the participant's physician. Please list all medications, including over the counter medications to be taken at Tiffany's Adult Day Care Center.

<b>MEDICATION</b>	<b>DOSAGE</b>
•	_____
•	_____
•	_____
•	_____
•	_____

**ADDITIONAL COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_

DATE \_\_\_\_\_