HCESC Thrive Day Habilitation Medical Form

General Information

(to be completed by physician)

Applicant Name: ____DOB:_______________

Primary Care Physician: ____

Address:____

Phone Number: ________________________ ______________________________

Date of Last Physical Exam: _______________________________________

Date of Last TB Test: ____ (Attach copy of results)

Hepatitis B Profile:________ ________ ________ Titer drawn / date________ Results__________

Medical History

Diagnosis:____

____

Recent hospitalizations (date and reason):

____

____

____

Surgeries: (date and procedure):

____

____

____

Does the applicant have a history of drug or alcohol abuse? ☐ yes ☐ no

If yes, describe: ____

Current Medications

Medication	Dosage/ Frequency	Possible Side Effects

Revised 5/2022

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Applicant Name: ____

<u>Emergency Medical Information</u>

Food and Allergies: Does the applicant have any allergies? ☐ yes ☐ no

If yes, submit **Authorization for Administration of Epinephrine Auto-Injector**

Does the applicant have dietary restrictions/ special diet? ☐ yes ☐ no

If yes, describe: ____

<u>Asthma</u>

Does the applicant have asthma ☐ yes ☐ no

If yes, submit an **Asthma Treatment Plan .**

Seizures: Does the applicant have seizures? ☐ yes ☐ no

If yes, submit **My Seizure Response Plan.**

Diabetes: Does the applicant have diabetes? ☐ yes ☐ no

If yes, submit **Diabetes Medical Management Plan (supplied by physician).**

<u>Mobility</u> (please check)

______ walks independently

______ uses walker/ cane / crutches

______ uses wheelchair

<u>Vision</u>

Does the applicant have a visual impairment? ☐ yes ☐ no Legally blind? ☐ yes ☐ no

If yes, describe: ____

Does the applicant wear glasses or contact lenses? ☐ yes ☐ no

Date of last eye examination: ____

<u>Hearing</u>

Does the applicant have a hearing impairment? ☐ yes ☐ no

If yes, describe: ____

Does the applicant wear hearing aids? ☐ yes ☐ no

Date of last hearing examination: ____

Physicians Signature: ____

Date: ____

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