



D. Any other disease or condition not mentioned on previous page:

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

E. Will this person wander off if not closely attended? \_\_\_\_\_ Yes \_\_\_\_\_ No

F. Will this person do harm to self, others or property without constant supervision?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

**2. Special Requirements/Recommendations for Care**

A. Medications

Name	Dosage	Frequency	Route
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Allergies \_\_\_\_\_ ASA \_\_\_\_\_ PCN \_\_\_\_\_ Other (specify below)

\_\_\_\_\_

C. Diet \_\_\_\_\_ As Tolerated/select \_\_\_\_\_ Supplements \_\_\_\_\_ Assistance Required

\_\_\_\_\_ Special Needs: \_\_\_\_\_

\_\_\_\_\_ Food intolerances: \_\_\_\_\_

D. Therapy/Other Services Currently Receiving (Please give agency name and phone number) Needed in Day Care?

Physical Therapy \_\_\_\_\_

Speech Therapy \_\_\_\_\_

Occupational Therapy \_\_\_\_\_

In Home Care \_\_\_\_\_  
(personal, nursing, home health agency, etc.)

## E. Physical Restrictions/Limitations

No Restrictions       Assistive Device       Poor Endurance

Other (specify): \_\_\_\_\_

**3. Is this person physically and mentally able to make an exit from the building in an emergency without assistance (i.e. without another person, wheelchair, walker, leg prosthesis or other device)?**

Yes       No

If assistance is needed, what type? \_\_\_\_\_

**4. Is this person free of tuberculosis in a communicable form?**

Yes       No

Type of test(s): \_\_\_\_\_

Date of test(s): \_\_\_\_\_ Test results: \_\_\_\_\_

EXAMINATION FOR TUBERCULOSIS IS TO BE COMPLETED WITHIN 30 DAYS PRIOR TO ACCEPTANCE FOR ADMISSION TO ADULT DAY CARE OR WITHIN 30 DAYS PRIOR TO ADMISSION.

Inappropriate for test to be given       Yes       No

If Yes, why? \_\_\_\_\_

**5. Is this person capable of administering his/her own medications?**

Yes       No

**6. Permission is given to administer acetaminophen, 500 mg, one or two tablets PO for minor complaints?**

Yes       No

**7. Verification of Above Information:**

MD Signature \_\_\_\_\_ Date \_\_\_\_\_

Print/Type Physician Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Please Return To:**

**Generations Crossing**

Revised 10/21/08

**3765 Taylor Spring Lane**

**Harrisonburg, VA 22801**

**(540) 434-4901**