LA EDAD PRODIGIOSA INC
18900 SW 106th AVE. STE 101-102
CULTER BAY FL 33157

**PARTICIPANT HEALTH ASSESSMENT**

**Patient's Name:**_______________________________________________

**Date of Birth:** _____/_____/_________ **Age:** _______ **Height:** _______ **Weight:** _____**Ibs.**
**Gender:** ❑ **Male** ❑ **Female**

**1. Medical History & Diagnoses:** ______________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_______________________________________________________________

**2. Allergies:** __________________________________________ **OR** ❑ **No Known Allergies**

**3. Physical or Sensory Limitations:** __________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
______________________________________________________________________

**4. Cognitive or Behavioral Status:** ____________________________________________
_____________________________________________________________________________
____________________________________________

**5. Should the participant be restricted for any medical reasons from performing any activities at the Adult Day Care Center, such as walking, exercise, etc.?** ❑ **NO** ❑ **YES (Specify):** _________________________________________________________________
_____________________________________________________________________________
____________

**6. Any psychiatric history?** ❑ **NO** ❑ **YES (Specify):**____________________________
_____________________________________________________________________________
__________________________________________________

**7. IS PATIENT FREE OF COMMUNICABLE DISEASES?**

❑ **YES – This patient is FREE from Tuberculosis in a communicable form and apparent signs and symptoms of other communicable diseases and does not constitute a risk of communicating disease to any person under the care of the Center.**

❑ **NO (Specify):**_________________________________________________________________

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**8. Is participant able to self-administer his/her medication while at the Adult Day Care Center? ❑ YES ❑ NO**

**9. Special Diet Instructions:❑ Regular ❑ Diabetic Diet ❑ No Salt Added ❑ Low Salt ❑ Low Fat / Low Cholesterol**

**Other special diet instructions: _____________________________________________________**

**10. Please list all current medications, including dosage and time medication is to be taken OR ❑ See attached medications list**

**1. ____________________________________________________________**
**2. ____________________________________________________________**
**3. ____________________________________________________________**
**4. ____________________________________________________________**
**5. ____________________________________________________________**
**6. ____________________________________________________________**
**7. ____________________________________________________________**
**8.______________________________________________________________**

**Physician's Attestation: I certify that I have reviewed the health assessment and examined this person on __________________________ and find him/her physically able to participate in the Adult Day Care Center.**

**Date of Examination:____________________________________________________________**

**Physician's Name: ______________________________ Signature: _________________ ______**

**Date: ___________________**

**Medical License #: _______________Tel#: _______________________ Fax#: _____________**

**Physician's Address: ______________________________________________________________**

**City State Zip**