

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ DATE: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Restrictions / Limitations / for Day Services / Employment: (Be specific - lifting/standing/sitting) \_\_\_\_\_

Special Dietary Needs / Textures: \_\_\_\_\_

Food / Drug Allergies: \_\_\_\_\_

Current Meds/Dosage/Route/Frequency	Reason	Current Meds/Dosage/Route/Frequency	Reason

\*\*Tetanus Toxoid: Date Given: \_\_\_\_\_ (Recommended every 10 years by ODH)

\*\*TB Testing: Date Given: \_\_\_\_\_ Date Read: \_\_\_\_\_ Negative  Positive  (Within 6 months of application)

If positive, Chest X-ray given: YES  NO  Results: \_\_\_\_\_

**I give the nurse permission to administer the following, per recommended label dosage during day program hours:**

**TYLENOL      ASPIRIN      ANTACID      THROAT LOZENGE      IBUPROFEN      OTHER \_\_\_\_\_**

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ FAX: \_\_\_\_\_