Annual Health Statement for Developing Potential, Inc.

Individual Name: _____ DOB: _____

Each question must be answered*; if not applicable, please indicate N/A*
Blood Pressure: _____ HR: _____ Height: _____ Weight: _____
Date of TB: _____ Results: □Negative □Positive (date of chest x-ray) _____
Date of last Dental Screening: _____ Date of last Vision Screening: _____

Diagnoses: _____

Diet Orders: □Regular □Pureed □Soft □Small bites (size):_____ □Mechanical soft
□NPO □Thickened Liquids □Other (specify):_____
Tube Feeding □No
□Yes Type and amount: _____
Time(s):_____
Water and amount: _____
Other special instructions: _____

Risk of Choking: **□No**
□Yes (if yes, what precautions should be put in place to ensure safety?)
_____

Allergies: **□None**
□Yes (please indicate)
_____
Life Threatening Allergies? □No □Yes:_____

Assistive Devices:
Wheelchair: **□ w/ Seatbelt** **□Gait Belts** **□Walker** **□Cane**
□ w/Out Seatbelt **□AFOs:_____□Splint(s):_____ □Other:_____**

Physical Limitations: **□No**
□Yes (please indicate)_____

Any Restrictions from participating in day habilitation or community integration?
□No **□Yes (please indicate) _____**
Individual is in good health and free from communicable disease
□Yes **□No: _____**

Can Individual eat/drink foods containing artificial sweetener: **□Yes** **□No**

Can sunscreen be used PRN: **□Yes** **□No**

Review of *ALL* Current Medications **□Yes** **□No** ***Please attach current medication list**
*All Current Medications for the individual must be reviewed by the physician annually:

Would Individual Benefit from Physical and/or Occupation Therapy Evaluation and Treatment: **□ Yes □ No**

*The Department of Mental Health requires that all individuals who receive medications must obtain a doctor's order to be kept on file at their respective day program. According to DPI policy in accordance with CARF standards, medication orders must be completed, reviewed by a physician and updated a minimum of every 12 months. All medication orders must be fully completed on DPI's "Medication Form"

Physician Signature: _____ Date:_____
Physician Name (print):_____
Physician Phone Number: _____

HB 9/2016; HB 8/2017