Pequeños Gigantes Adult Day Care
16 NW 26 Avenue, Miami, FL 33125
Phone: (786) 558 7888 Fax: (786) 762 2970
E Fax (305) 675 2299

PARTIPANT'S HEALTH ASSESMENTS

Name: _____ **DOB:** _____

Know Allergies: _____

Height: _____ **Weight:** _____

Medical history and diagnosis: _____

_____

_____

Cognitive or behavioral Status: _____

_____

Any contagious disease (s) : Yes _____ **No** _____

Date of X-ray: _____ **or Date Tuberculin Test given:** _____

Result of Chest X-ray: _____**or Result TB test:** _____

(Free from tuberculosis and other communicable diseases)

Is a participant able to self–administer the medication while at the Adult Day Care? Yes_____ **or No** _____

Does the participant have any psychiatric history?

Yes_____ **or No** _____ **If yes please comment:** _____

Should the participant be restricted for medical reasons, from performing any activities at the Day Care (walking, exercises, etc.)

Yes_____ or No _____ If yes specify: _____

SPECIAL DIET INTRUCTIONS?

Regular: _____ Diabetic Diet: _____

No added salt: _____ Low fat low cholesterol: _____

ADULT DAY CARE provided breakfast, lunch and snacks. The Food is a regular diet and contains a minimal of salt, low cholesterol and low fat.

Please list all current medications including dosage and time me medication is to be taken.

1. _____
2. _____
3. _____
4. _____
5. _____

I certify that I have reviewed the health assessment and examined this person and find him/her physically able to participate in the Adult Day Care.

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN: _____

NAME OF THE PHYSICIAN (PRINT): _____

MEDICAL LICENSE #: _____

ADDRESS OF PHYSICIAN: _____

TELEPHONE: _____