Board Policy H-1 Attachment A

LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
PHYSICAL EXAMINATION

Admission ☐
Periodic ☐

Please fill in all blanks. If any are not appropriate indicate N/A

1) **Name of Patient**:_____ **Date**:_____

Address:_____ **Phone #**:_____

2) **Primary Care Physician**:_____ **Phone #**:_____

Address:_____

3) **Sex**: Male:_____ Female:_____ **Date of Birth**:_____

4) **Allergies/Adverse Reactions**: **(Food, Drug, Environment)**

Type:_____ **Symptoms**:_____

_____ _____

5) **Diagnosis**:_____

6) **Seizures**: **Type**:_____

7) **Medications:** **Dosage:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

8) **Immunization History:**

	1st	2nd	3rd	Booster	Booster
DPT/DTaP/DT					
Td (tetanus)					
MMR					
Pneumovax					
Influenza					
Hepatitis Vaccine					
HiB					
Comvax					
Polio OPV					
IPV					
Varicella					
Other					

*Indicate if medical or religious contraindications are present

9) **History of Chronic Medical Problems**:_____

_____

10) **Vitals**: Height:_____ in Weight:_____ lbs B/P: _____

Temp:_____ Pulse:_____ Resp:_____

11) **Vision Screening:_____** **Hearing Screening:_____**

PHYSICAL EXAM	**NORMAL**	**FINDINGS**
Head		
Skin		
Ears		
Neuro		
Nose		
Throat		
Mouth		
Neck		
Chest		
Heart		
Lung		
Abdomen		
Genitalia		
Rectum		
Extremities		
Back		

Are there any problems with locomotion or coordination?_____

Explain:_____

Is there any evidence of scoliosis, kyphosis, or unequal leg length? _____ Yes _____ No

Explain:_____

C-Spine films (recommended for individuals with Down's Syndrome)

_____ Yes _____ No Results/Date:_____

12) **TB Status (Required):**

TB Mantoux Test: _____(date) / _____(result) OR

Chest X-Ray if Mantoux is Positive: _____(date) / _____(result) OR

Negative Risk Assessment:_____

13) **What do you consider to be the etiology of the developmental disability and when was the diagnosis determined?**_____

_____

14) **Are there any diet restrictions?**: _____ Explain:_____

_____

15) **Optional Testing**: date / results

PAP Test (females 18 years & older): _____ / _____

Mammogram (females 35 years & older): _____ / _____

Hemoccult (everyone 40 years & older): _____ / _____

16) **Additional tests per Physician request**: _____

_____

17) **Optional Lab Work**: (date/results)

CBC: _____ / _____

Urinalysis: _____ / _____

RPR: _____ / _____

Hepatitis B Screen:_____ / _____(if no proof of immunity or immunization)

(HB Ag): _____ / _____

(Anti-HB): _____ / _____

18) Atypical behavior patterns and emotional responses:_____

_____

19) Participation in activities: Full participation: _____

Restricted participation: _____

20) List restrictions and explain (including the use of any appliance or lifting restrictions):_____

_____

21) Summary of medical data/diagnosis relevant to programs and learning:_____

_____

_____

22) **FREEDOM FROM COMMUNICABLE DISEASE:**

I certify that no communicable disease is evident at the time of this examination.

_____ Yes _____ No

22) Physician has informed individual/guardian of his/her medical status.

_____ _____
Physician Signature Date

_____
Physician's Name (please print)

Board Policy H-1 Attachment B

LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
HEALTH HISTORY

Name:_____**Sex**:_____**DOB:**_____

Address:_____

1) **Significant Family History**: (did anyone in your family ever have -- please check all that apply)

_____ Heart Disease _____ Diabetes _____ Kidney Problems
_____ Alcoholism _____ Cancer _____ Tuberculosis
_____ Epilepsy/Seizures _____ Neurological _____ Mental Illness
_____ Other:_____ _____

2) **Past Medical History**: (please check and include dates if possible)

PART A:

_____ Rheumatic Fever _____ Arthritis _____ Asthma
_____ Polio _____ Tuberculosis _____ Frequent Colds
_____ Pneumonia _____ Eczema _____ Chicken Pox
_____ Strep/Scarlet Fever _____ Pleurisy _____ Measles
_____ Meningitis _____ Diabetes _____ German Measles
_____ Cancer _____ Heart Disease _____ Hepatitis
_____ Tonsillitis _____ Chronic Ear Infections
_____ Tobacco Use ___ yes ___ no What Form _____ _____Quantity Per Day
_____ Other

PART B: (include dates if possible)

Past Surgery:_____

_____

Past Injuries:_____

_____

Recurring Medical Problems:_____

_____

Past/Present Behavior/Psychiatric Problems:_____

_____

Does Applicant Have Difficulty With: (*if yes, describe below)

Vision: _____ Date of last eye exam:_____Wears corrective lenses:_____
Hearing: _____ Date of last hearing eval:_____ Wears hearing aide_____
Speech:_____ Receives or has received speech therapy _____
Eating:_____

Ability to control bowels:_____Ability to control urine:_____

*Describe any difficulty with the above:_____

_____
_____

PART C:
Status of Ambulation:
_____ Independent _____ Semi-Independent _____ Crutches _____ Cane
_____ Non-Amb _____ Wheelchair _____ Walker _____ Braces
Does individual have any problems in use of arms, hands, legs or walking? If so, explain:
_____
_____

PART D:
Does applicant have/use any of the following?: (please check)
_____ Special Bathing Equip _____ Diaper/Depends _____ Eating Devices
_____ Tracheostomy _____ Hearing Aid _____ Prosthesis (dentures,etc)
_____ Pacemaker _____ Urinary Devices _____ Special Shoes
_____ Vascular Devices _____ Eye Glasses _____ Ostomy (type)
_____ Gastrostomy (type) _____ Respiratory Equip _____ Other:_____

PART E: (Female Applicants)
Is Menstruating? _____ Yes _____ No Periods: _____ Regular _____ Irregular
Special Needs:_____
_____

3) **Nutrition:**

A) Requires Special Diet:_____ Yes _____ No

If yes: Food Supplement:_____

Modified texture / diet:_____

4) **Allergies**:

A) Foods: _____ Yes _____ No If yes, what foods and symptoms:_____
_____

B) Environmental Substances: (include animals if applicable) _____ Yes _____ No
If yes, what and
symptoms:_____

C) Medication Allergies: If yes, what and
symptoms:_____
_____

5) **Skin Problems**: (list any below)
_____
_____

6) **Seizure Disorder**:

Type and Frequency:_____

Age of Onset and Cause (if known):_____

Date of Last Seizure:_____

Other Comments:_____

_____

6) **Current Medication Schedule**: (include fluoride & vitamin supplements)

TYPE	DOSAGE & FREQUENCY	PURPOSE FOR MEDICATION

8) **Physician**:

Name:_____ Phone:_____

Address:_____

9) **Psychologist/Psychiatrist:**

Name:_____ Phone:_____

Address:_____

10) **Neurologist Name:**

Name:_____ Phone:_____

Address:_____

11) **Dentist**:

Name:_____ Phone:_____

Address:_____

12) **Insurance Information**:

Medicaid: _____ Yes _____ No Number:_____

Medicare: _____ Yes _____ No Number:_____

Medicare Part D: _____ Yes _____ No Provider:_____

Number:_____

Other Insurance:_____

Signature Individual/Parent/Guardian/Family Member:_____

Name:____ _____ Date:_____

Address:_____ Phone:_____

_____ Wk Phone:_____

LAKE COUNTY BOARD OF DD/DEEPWOOD
DENTAL EXAMINATION AND CHARTING

Patient Last Name, First
Responsible Party of Medicaid Number
Address
Home Phone Work Phone
Existing Illnesses, Medications
Existing Prostheses Date of Prior Placement /
Condition of Ridges, Upper/Lower Oral Hygiene /

Date	Services	Doctor's Signature

Date	Treatment Plan	Date	Treatment Plan

HN 02/18

Board Policy H-1 Attachment D
LAKE COUNTY BOARD OF DD/DEEPWOOD

NURSING SERVICES
ANNUAL RESIDENTIAL PHYSICAL EXAMINATION

1) **NAME**:_____ 2) **DOB**:_____ 3) **SEX**: M____ F____

4) **DIAGNOSIS**:_____

_____

5) **ALLERGIES/ADVERSE REACTIONS**:_____

6) **IMMUNIZATION HISTORY**: (Prior 12 months)

dT_____ date/result TB PPD_____ date/result or
Pneumovax_____ date/result Chest X-ray_____ date/result
Influenza_____ date/result _____

7) **SEIZURE**: Yes:_____ No:_____ Type:_____ Frequency:_____

8) **VISION EXAM**:_____date 9) **HEARING SCREENING**:_____

date

10) **MENSTRUAL HISTORY**: LMP:_____ PAP:_____ date

11) **DIET**:_____

12) **SIGNIFICANT PAST MEDICAL / SURGICAL HISTORY**:_____

_____

_____

13) **VITALS**: HT:_____ WT:_____ B/P:_____

Temp:_____ Pulse:_____ Resp:_____

14) **PHYSICAL EXAMINATION**:

	NORMAL	FINDINGS
HEAD		
SKIN		
EARS		
NEURO		
NOSE		
THROAT		
MOUTH		
NECK		
CHEST		
HEART		
LUNG		
ABDOMEN		
GENITALIA		
RECTUM		
EXTREMITIES		
BACK (scoliosis, kyphosis)		

15) **Atypical behavior patterns/emotional responses**:_____

_____

16) **Recurring Medical Problems**:_____

_____

17) **Summary of medical data/diagnosis and recommendations**:_____

_____

18) **Participation in activities**: Full participation:_____ Restricted participation:_____

List restrictions and explain (including the use of any appliance or lifting restrictions):_____

_____

19) **Freedom from communicable disease**:

I certify that no communicable disease is evident at the time of this examination.

_____ Yes _____ No

20) **Physician has informed individual of his/her medical status**:

_____ _____ _____

Signature of Physician Physician's Name (Please Print) Date

_____

_____

Address

_____

Phone #

HN 02/18
M:\Habilitation\BDPOLICY\H-01 forms.doc

Board Policy H-1 Attachment E

LAKE COUNTY BOARD OF DD/DEEPWOOD
BROADMOOR SCHOOL 8090 Broadmoor Rd., Mentor, Oh 44060

Preschool – Physical & School Age Update

Name of Child:_____

Parent/Guardian:_____ DOB:_____

Immunization Record:	Dose 1	Dose 2	Dose 3	Dose 4
DPT DtaP/DT/Td				
Polio (OPV/IPV)				
MMR		XXXXXXXXXX	XXXXXXXX	XXXXXXXXX
Hib				
HEP				XXXXXXXXX
COMVAX				XXXXXXXXX
Other:				

Height:_____ Weight:_____ Teeth (T):_____ (P):_____

Required Testing:

TB Mantoux Test: _____(date) / _____(result) OR

Chest X-Ray if Mantoux is Positive: _____(date) /_____ _____(result) OR

Negative Risk Assessment:_____

HCT:_____ date / _____ result Follow up: Yes _____ No _____

Lead:_____ date / _____ result Follow up: Yes _____ No _____

Vision Screening: Date Done:_____

Distance Acuity	Right:	Left:	
Muscle Balance	Pass:	Fail:	Not Done:
Farsightedness	Pass:	Fail:	Not Done:
Color	Pass:	Fail:	Not Done:
Child Wears Glasses?	Yes:	No:	
Tested with Glasses?	Yes:	No:	
Referral Made?	Yes:	No:	

Hearing Screening: Date Done:_____

Audiometric Results Right Ear	Pass:	Fail:	Not Done:
Audiometric Results Left Ear	Pass:	Fail:	Not Done:
Child Wears Hearing Aid?	Yes:	No:	
Tested with Hearing Aid?	Yes:	No:	
Referral Made:	Yes:	No:	

CONTINUED ON BACK

LAKE COUNTY BOARD OF DD/DEEPWOOD BROADMOOR SCHOOL
Preschool – Physical & School Age Update

Board Policy H-1 Attachment E

Name of Child:_____

PHYSICAL EXAMINATION:

	Findings		Findings
Head		Lungs	
Nose		Abdomen	
Mouth		Genitalia	
Throat		Rectum	
Teeth		Extremities	
Neck		Back	
Heart		Skin	

Current Medication(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I certify that no communicable disease is evident at the time of this examination and the child is in suitable condition for enrollment in a pre-school program.

_____ _____

Physician's Signature Physician's Name & Address

_____ _____

Date of Exam

_____

Board Policy H-1 Attachment F

LAKE COUNTY BOARD OF DD/DEEPWOOD

PRESCHOOL DENTAL EXAMINATION

Name:_____

Parent/Guardian:_____

D.O.B.:_____ Date of Exam:_____

Oral Hygiene:_____

(T) Teeth:

_____
_____
_____
_____

(P) Teeth:

_____
_____
_____
_____

Treatment:

_____
_____
_____
_____

Recommendations:

_____
_____
_____
_____

Doctor's Signature: _____

HN 02/18
M:\Habilitation\BDPOLICY\H-01 forms.doc

Board Policy H-1 Attachment G
LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
ANNUAL ADULT SERVICES

PHYSICAL EXAMINATION

1) **NAME**:_____ 2) **DOB**:_____ 3) **SEX**: M____ F____

4) **DIAGNOSIS**:_____

_____

5) **ALLERGIES/ADVERSE REACTIONS**:_____

6) **IMMUNIZATION HISTORY**: (Prior 12 months)

dT_____ date/result TB PPD_____ date/result or
Pneumovax_____ date/result Chest X-ray_____ date/result
Influenza_____ date/result _____

7) **SEIZURE**: Yes:_____ No:_____ Type:_____ Frequency:_____

8) **VISION EXAM**:_____date 9) **HEARING SCREENING**:_____

date

10) **MENSTRUAL HISTORY**: LMP:_____ PAP:_____ date

11) **DIET**:_____

12) **SIGNIFICANT PAST MEDICAL / SURGICAL HISTORY**:_____

_____

_____

13) **VITALS**: HT:_____ WT:_____ B/P:_____

Temp:_____ Pulse:_____ Resp:_____

14) **PHYSICAL EXAMINATION**:

	NORMAL	FINDINGS
HEAD		
SKIN		
EARS		
NEURO		
NOSE		
THROAT		
MOUTH		
NECK		
CHEST		
HEART		
LUNG		
ABDOMEN		
GENITALIA		
RECTUM		
EXTREMITIES		
BACK (scoliosis, kyphosis)		

Name:_____

15) **Atypical behavior patterns/emotional responses**:_____

_____

16) **Recurring Medical Problems**:_____

_____

17) **Summary of medical data/diagnosis and recommendations**:_____

_____

18) **Participation in activities**: Full participation:_____ Restricted participation:_____

List restrictions and explain (including the use of any appliance or lifting restrictions):_____

_____

19) **Freedom from communicable disease**:

I certify that no communicable disease is evident at the time of this examination.

_____ Yes _____ No

20) **Physician has informed individual of his/her medical status**:

_____ _____ _____

Signature of Physician | Physician's Name (Please Print) | Date

_____

_____

Address

_____

Phone #