ABLE TRAINING CENTER
3100 NORTH GEORGE STREET, YORK, PA 17406
PHONE: (717) 384-6130 FAX: (717) 855-2533

PROGRAM PARTICIPANT PHYSICAL FORM

Program Participant (Last Name):	Program Participant (First Name):	Date of Birth:
Parent/Guardian Name (if applicable):	**Guardian Phone# (if applicable):**	

Review of Previous Medical History (Attach Additional Pages if Necessary):

Overview of Past Medical History (MUST include diagnoses):

Developmental Information:

Family/Social Information:

Current Medications: N_____ Y_____

***Attach additional pages if necessary**

Name	Dosage	Times/Day

Allergies: N_____ Y_____ (specify)_____

Contraindicated Medications: N_____ Y_____ (specify)_____

Height:	Weight:	Blood Pressure:
_____ inches _____ percentile	_____ lbs. _____ percentile	_____ / _____

General Physical Examination:	Normal:	Abnormal/Comments:
Head/Ears/Eyes		
Nose/Throat		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints		
Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental (EG, DDST)		

Hearing Screening (as recommended):	Vision Screening (as recommended):
Is a screening recommended? **N**_____ **Y**_____	Is a screening recommended? **N**_____ **Y**_____
Right Ear: Pass_____ Fail_____	R: 20 / _____ L: 20 / _____
Left Ear: Pass_____ Fail_____	Wears corrective lenses? Y_____ N_____

Tuberculosis (TB) Screening:	**Date Administered:**	**Abnormal/Comments**
Screening Required? N_____ Y_____		

Communicable Disease Statement:	
Does the indivudal have a serious communicable disease? N_____ Y_____	If yes, what specific precautions must be taken to prevent the spread of the disease to other individuals?: (Attach Additional Pages if Necessary)

Any Health Maintenance Needs (ex. exercise, hygiene practices, weight control, etc.), Medication Regimen, and/or Need for Blood Work at Recommended Intervals?: N_____ Y_____

If Yes, please describe. Attach additional pages if necessary.

Any Physical Limitations?: N_____ Y_____

If Yes, please describe. Attach additional pages if necessary.

Any Special Instructions for the Individual's Diet?: N_____ Y_____

If Yes, please describe. Attach additional pages if necessary.

Immunizations: See Attached _____

	Date	**Date**	**Date**	**Comments:**
Dtap (must be within the last 10 years):				

Any medical information pertinent to the individual's diagnosis and treatment in case of an emergency?: N_____ Y_____

If Yes, please describe. Attach additional pages if necessary.

Any Special Instructions/Additional Comments?: N_____ Y_____

If Yes, please describe. Attach additional pages if necessary.

PHYSICIAN'S RECOMMENDATION: To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

[X] ICF/MR Care (Services to be provided at home or in an intermediate care facility for the intellectually disabled.)

Medical Care Provider Name (PRINT):	**Address/Phone #:**

_____ _____

Signature of Physician/Certified Practitioner ***Date of Examination***