**ABLE TRAINING CENTER**
**3100 N. George St., York, PA 17406**
**PHONE: (717) 384-6130 FAX: (717) 855-2533**

# PARTICIPANT PHYSICAL FORM

| Program Participant (Last Name): | Program Participant (First Name): | Date of Birth: |
|---|---|---|
| | | |
| **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 Medication Regimen: Attached _____**

| Name | Dosage | Times/Day |
|---|---|---|
| | | |
| | | |
| | | |

**Allergies/Contraindicated Medications: N_____ Y_____**

If yes, specify:

**General Physical Examination Completed: N_____ Y_____**

| Height: | Weight: | Blood Pressure: |
|---|---|---|
| | | _____ / _____ |

| "X" if Abnormality Exists | | List Abnormality | "X" if Abnormality Exists | | List Abnormality |
|---|---|---|---|---|---|
| | Head/Ears/Eyes | | | Extremities/Joints | |
| | Nose/Throat | | | Back/Chest | |
| | Cardiorespiratory | | | Skin/Lymph Nodes | |
| | Abdomen/GI | | | Neurologic/Tone | |
| | Genitalia/Breasts | | | Other (specify) | |

**Assessments/Screenings: *MUST BE COMPLETED (or have results from other vision/hearing assessments attached)**

| | | | |
|---|---|---|---|
| **VISION** | **Normal by Observation _____** | **Normal w/ Correction _____** | **Abnormal* _____** |
| ***If Abnormal, Must Provide Recommendation:** | | | |
| **HEARING** | **Normal by Observation_____** | **Normal w/ Correction _____** | **Abnormal* _____** |
| ***If Abnormal, Must Provide Recommendation:** | | | |

**Tuberculosis (TB) Screening (every 2 years):**

| Date Administered: | Date Read: | Results: |
|---|---|---|
| | | Negative_____ Postive_____ |

| **Immunizations: Up to Date _____** |
|---|
| **Tetanus/Diphtheria Booster Date (every 10 years):** |

| **Does the individual have a Serious Communicable Disease? N_____ Y_____** |
|---|
| If yes, what precautions must be taken to prevent the spread of the disease to other individuals? |

**Medical information Pertinent to the Individual's Diagnosis and Treatment in Case of an Emergency:**
***Check all that apply**

| | | | |
|---|---|---|---|
| | None | | Psychiatric Diagnosis |
| | Seizure Disorder | | Non-Ambulatory |
| | Blind | | Non-Verbal |
| | Deaf/Hearing Impaired | | May need assistance to evacuate |
| | Diabetic | | Other (specify): |

| **Does the Individual have any Health Maintenance Needs (ex. exercise, hygiene practices, weight control, etc.)?: N_____ Y_____** |
|---|
| If Yes, please describe. Attach additional pages if necessary. |

| **Does the Individual have a need for Blood Work at Recommended Intervals?: N_____ Y_____** |
|---|
| If Yes, please describe. Attach additional pages if necessary. |

| **Does the Individual have any Physical Limitations or Activity Restrictions?: N_____ Y_____**<br>**(any activity that requires hands-on physical assistance or adaptive equipment for the individual to perform)** |
|---|
| If Yes, please describe. Attach additional pages if necessary. |

| **Any Special Instructions for the Individual's Diet?: N_____ Y_____**<br>**(any dietary needs, including how food is to be prepared and served)** |
|---|
| 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 below.

| | |
|---|---|
| X | ICF/IDF Care<br>(Services to be provided at home or in an intermediate care facility for the intellectually disabled.) |

| ***Signature of Physician/Certified Practitioner*** | **Date of Examination:** | |
|---|---|---|
| | | |
| **Physician/Certified Practitioner Name (PRINT):** | **Address:** | |
| | **Phone #:** | |