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:

VISION:	Normal _____	Normal w/ Correction _____	Abnormal* _____
***If Abnormal, Must Provide Recommendation:**			
HEARING:	**Normal _____**	**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_____ **(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_____ **(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 (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 #:	