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

Screenings:

Hearing Screening (as recommended):	**Normal ______**	**Abnormal ______**	**Not Checked______**
Vision Screening (as recommended):	**Normal ______**	**Abnormal ______**	**Not Checked______**

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 #:	