HCESC Day Habilitation Medical Form

General Information

(to be completed by physician)

Applicant Name: _____DOB:_____

Primary Care Physician: _____

Address:_____

Phone Number: _____ _____

Date of Last Physical Exam: _____

Date of Last TB Test: _____ (Attach copy of results)
Hepatitis B Profile:_____ _____ _____ Titer drawn / date_____ Results_____

Medical History

Recent hospitalizations (date and reason):

_____
_____
_____

Surgeries: (date and procedure):

_____
_____
_____

Does the applicant have a history of drug or alcohol abuse? ☐ yes ☐ no
If yes, describe: _____

Emergency Medical Information

Food and Allergies: Does the applicant have any allergies? ☐ yes ☐ no
If yes, submit **Authorization for Administration of Epinephrine Auto-Injector**

Does the applicant have dietary restrictions/ special diet? ☐ yes ☐ no
If yes, describe: _____

Asthma

Does the applicant have asthma ☐ yes ☐ no
If yes, submit an **Asthma Treatment Plan .**

Seizures: Does the applicant have seizures? ☐ yes ☐ no
If yes, submit **My Seizure Response Plan.**

Diabetes: Does the applicant have diabetes? ☐ yes ☐ no
If yes, submit **Diabetes Medical Management Plan (supplied by physician).**

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Applicant Name: _____

Mobility (please check)
_____ walks independently
_____ uses walker/ cane / crutches
_____ uses wheelchair

Vision
Does the applicant have a visual impairment? ☐ yes ☐ no Legally blind? ☐ yes ☐ no
If yes, describe: _____
Does the applicant wear glasses or contact lenses? ☐ yes ☐ no

Date of last eye examination: _____

Hearing
Does the applicant have a hearing impairment? ☐ yes ☐ no
If yes, describe: _____
Does the applicant wear hearing aids? ☐ yes ☐ no

Date of last hearing examination: _____

Physicians Signature: _____

Date: _____

HCESC Day Habilitation Medical Form

Nurse Authorization for RX/OTC Medication Administration

(to be completed by physician)

This form is to be completed for all medications other than asthma medications and epinephrine.

- Original copy of this form is required by the NJ State law.
- State law requires that medication be renewed each year. Year:_____
- Only one medication per form.

Name_____ DOB _____Date _____

Diagnosis _____

Allergies_____

Medication _____

Dosage_____ Time/Frequency _____Route_____

Possible Side Effects _____

MEDICATION ORDER FOR TRIP DAYS (Please note most trips are full day)

___ Dose may be omitted ___ Dose to be given on return to THRIVE_____.

___ Other (please specify):_____

MEDICATION ORDER FOR EARLY DISMISSAL

___ Omit afternoon dose ___ Maintain original order

***In the event that the consumer is not given their morning dose at home, the nurse may give the medication listed above with client / parental permission*. AM DOSE: _____**

_____ _____ _____

Provider's Signature **Office Stamp** **Date**

Client / Parent / Guardian Consent for Giving Medication

(To be submitted with the Nurse Authorization for RX/OTC Medication Administration

I request and give my consent for the Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the Nurse in the original pharmacy container labeled with the client's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of_____

I give permission for the nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

I request that _____ be assisted in taking the medication described below at THRIVE by the Nurse or other individuals authorized to administer medication to clients. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the nurse and others may require their presence at another location at the time that the medication is needed. I understand that the Hunterdon County Educational Services Commission, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the Hunterdon County Educational Services Commission, its agents and employees against any claims arising out of administration or lack of administration of this medication.

Applicant Signature: _____

Caregiver/ Guardian Name (please print) : _____

Caregiver/ Guardian Signature: _____

Today's Date: _____

HCESC Day Habilitation Medical Form

Client/ Parent/ Guardian Authorization To Administer PRN Medication

(To be kept confidential upon completion)

Name of Client : _____ DOB: _____

Diagnosis/Illness: _____

_____ **Medication**: Tylenol/ Acetaminophen

Dosage/Route: 325mg-650mg (based on age and weight) By Mouth

Frequency/Time: Every 4-6 Hours as needed for headaches/ pain

Special Directions:_____

Possible side effects:_____

_____ **Medication:** Advil/Motrin/Ibuprofen

Dosage/Route: 200 mg-400 mg (based on age and weight) By Mouth

Frequency/Time: Every 6-8 Hours as needed for headaches/ pain

Special Directions:_____

Possible Side Effects: _____

_____ **Medication**: TUMS/ Antacid

Dosage/Route: 1-2 Tablets (based on age and weight) By Mouth

Frequency/Time: As needed for stomach discomfort according to manufacturer's directions.

Special Directions: _____

Possible Side Effects: _____

I/We authorize the Nurse or, in his/her absence, the program director or his/her designee, to administer the above medication as indicated by my initials. I/We understand and agree that the THRIVE Day Habilitation Program, the Nurse and the Program Director shall not be liable for any injury to the client resulting from the administration of the medication as authorized by my signature below.

_____

(Signature of Client)

_____ _____

(Signature of Parent/Guardian) (Print)

Date _____