CITIZENS OPTIONS UNLIMITED, INC.
2021
MEDICAL INFORMATION PAGE

Name: _____

Dear Parents and Guardians,

Please submit this entire packet with the required information attached, signed and dated by a health care provider. The medical forms, information and dates must encompass the person's entire time at the program during the 2021 season. All forms are due no later than _____

To ensure a place in the program, the medical packet must be received, signed and completed in it's entirety by _____ if it is not time/too early for your child's regular physical exam, ask your health provider for a "program assessment appointment."

***** PLEASE BE ADVISED IF YOUR CHILD'S MEDICAL FORMS ARE NOT COMPLETED IN THEIR ENTIRETY AND SIGNED/STAMPED BY A HEALTH CARE PROVIDER, THEY MAY BE RETURNED FOR CORRECTION**. ***

1. ☐ **ANNUAL PHYSICAL EXAM/ ASSESSMENT-** ANNUAL PHYSICAL EXAM (MUST ENCOMPASS ALL THE DAYS THE INDIVIDUAL IS ATTENDING THE PROGRAM). 2021 Physical exam/ assessment paperwork must be dated within 365 days prior to the start of the program session.
    - The annual physical exam/ assessment ***must*** include all medication orders and treatments prescribed to the individual.

2. ☐ **Copy of FULL Immunization Record.** (signed and dated by the physician)
The program maintains immunization records for all individuals which includes dates for all immunizations against diphtheria, Haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, varicella, covid-19, and tetanus booster within the last 10 years. The record must be kept on file for every individual and ***updated annually.***

A full vaccination record with signature from the Health care provider can be attached.
Please provide evidence of 2 Measles vaccines or positive Measles titers.

CITIZENS OPTIONS UNLIMITED, INC.
PHYSICAL EXAM 2021

Name_____

Date of Birth: _____
Date of Exam: _____

ALLERGY

NKA ☐ _____
Medication ☐ _____
Food ☐ _____
Environmental ☐ _____

EPI-PEN ☐ _____

Medical History

Medical/Psychiatric Issues	**Surgeries**	**Implanted devices**:
_____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ ____ _____ _____ __ _____ _ _____ _	☐ Shunt ☐ Insulin pump ☐ Glucose Monitor ☐ Baclofen pump ☐ Pacemaker ☐ VNS ☐ **OTHER**: _____ _____

MEDICATIONS

All medications (including vitamins, supplements & over the counter medications) the individual takes should be listed here or attached to this form, an additional page can be added and signed by the doctor and must include all categories listed below.

Medication/ Strength (mg or ml)	**Dose and Frequency**	**Route**	**Indication/Desired Effect**	**Special Comments: include special directions, i.e. Crushed given in applesauce, etc.**
EXAMPLE ONLY Acetaminophen 325mg	2 tabs Twice a day	By mouth	Pain relief	Whole with Water

EMERGENCY PRN MEDICATION PROTOCOLS

(i.e. for activity or behavioral issues)

Purpose (ie. Medication protocol /Behavior)	**Medication**	**Doses, frequency**	**Route**	**Special Considerations**

Medical Guidelines/Protocols (i.e. insulin, bowel, tube feedings, behavior)

CITIZENS OPTIONS UNLIMITED, INC.
PHYSICAL EXAM 2021

Name: _____

Height _____ BP _____ Pulse/o2% _____

Weight _____ Temp_____ Respirations _____

Skin Risk For skin break down?
Head/Neck/Thyroid:
Nose/Throat:
Eyes/Vision: Right Left Corrective Lenses: ☐ yes ☐no
Ears/Hearing: Hearing Aids: ☐ yes ☐ no
Dentition: Dentures : ☐yes ☐no
Neuro/Behavioral: Seizures: ☐yes ☐no
Cardiac: EKG Abnormalities:
Chest/Breast Exam: Mammogram Abnormalities:
Pulmonary:

MOBILITY LIMITATIONS/RESTRICTIONS:

Activity	OK	Avoid	Limit	Describe Limit
Walking	☐	☐	☐	_____
Kneeling	☐	☐	☐	_____
Pulling	☐	☐	☐	_____
Pushing	☐	☐	☐	_____
Reaching	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

DIETARY GUIDELINE/RESTRICTIONS:

Diet:_____

_____

_____

_____

ADAPTIVE EQUIPMENT/SCHEDULE OF USE:

For all campers that require a shower chairs, a seat belt will be used unless specified otherwise.

_____

_____

_____

Abdomen/GI:
Recto/Procto:
Renal/Urinary:
Genitalia/Gynecological: Pap Smear Abnormalities:
Back/Spine/Extremities:
Other

Physician signature _____

Date: _____

(Print or Stamp)
Physician Name_____

Address _____

Telephone # ( ) _____

CITIZENS OPTIONS UNLIMITED, INC.

2021 Immunization Record

Immunization record which must include immunization dates against:
Diphtheria, Tetanus, Pertussis, Haemophilus influenza type B (HIB), Hepatitis B, Measles, Mumps, Rubella (MMR), Poliomyelitis, Varicella, Covid-19, and Tetanus Booster within the last 10 years.
Immunization records must be kept on file and updated ANNUALLY.
Please complete the form below or attach a copy of full Immunization Record.

Provide the month and year for each immunization.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Booster Month/Year
***Diphtheria, tetanus, pertussis** (DTaP) or (TdaP)						
***Tetanus booster** (dT) or (TdaP)						
***Mumps, measles, rubella** (MMR)						
***Polio** (IPV)						
***Haemophilus influenza type B** (HIB)						
Pneumococcal (PCV)						
***Hepatitis B**						
***Varicella** (Chicken pox)	☐Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:	☐ Negative	☐ Positive			
Covid-19						
Other vaccine:						

Medical Provider's Signature: _____ Circle one: M.D. D.O. C.N.P. P.A.

Date signed: _____/_____/_____

This form MUST be stamped by health provider

Rev. 02/2020

READY TO GO FORM – Parent/Guardian please complete

INDIVIDUAL'S INFORMATION Last Updated _____

Name (Last, First, MI)	DOB	Residence Phone	Hospital Preference
Address	Medicaid ID	Medicare ID	Other Insurance
	Language Spoken	Communication	Legal Status
	Religion		
Does the individual have a guardian? Yes ☐ No ☐ If YES, provide name, relationship, and contact number:			

CONSENT

Person(s) Authorized to Give Consent:		
Individual		
Name (First and Last)	Relationship	Telephone Numbers (h) (w) (c)
Address (City, State, Zip)		
Name (First and Last)	Relationship	Telephone Numbers (h) (w) (c)
Address (City, State, Zip)		

ADVANCED DIRECTIVES

Non-Hospital DNR Order In Effect? Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
Health Care Proxy? Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
Other Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
If YES to Other, specify (i.e. MOLST, Living Will):	

DIET AND CONSISTENCY

ALLERGIES

Medication Allergies (list with description of reaction if known):
Food Allergies (List)
Other (Latex, environmental, etc.)

MEDICATIONS (See Attached Copy of Current Medication Administrative Record)

Rev. 9/2017

INDIVIDUAL'S NAME: Last Updated:_____

Routine medication given: If Other, Specify:

PRIMARY HEALTH CARE PROVIDER

Name	Address (City, State, Zip)	Phone: Fax:

PHARMACY

Name	Address (City, State, Zip)	Phone: Fax:

MEDICAL HISTORY

Diagnosis
Past Procedures/Surgery

BASELINE

Vital Signs	T	P	R	BP	HT	WT	WT Date
Neurological/Mental Status (describe typical)							
Behavioral (PICA, etc.)							

IMMUNIZATIONS (most recent)

Tetanus Date	Pneumovax Date	Influenza Date	Varicella Date	Varicella Status	Other
TB Status (mm)	PPD Date	Hepatitis B Status	Hepatitis C Status		

ADDITIONAL CONTACT INFORMATION

Agency Name: Administrator/designee	Telephone Day Time: After Hours:
RN	Telephone Day Time: After Hours:
Care Manager	Telephone Day Time: After Hours:
Other Relationship	Telephone Day Time: After Hours:

INDIVIDUAL'S NAME: Last Updated:_____

ADDITIONAL INFORMATION
Other: