

Board Policy H-1 Attachment A

LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
PHYSICAL EXAMINATION

Admission
Periodic

Please fill in all blanks. If any are not appropriate indicate N/A

1) **Name of Patient:** _____ **Date:** _____
Address: _____ **Phone #:** _____

2) **Primary Care Physician:** _____ **Phone #:** _____
Address: _____

3) **Sex:** Male: _____ Female: _____ **Date of Birth:** _____

4) **Allergies/Adverse Reactions:** (Food, Drug, Environment)
Type: _____ **Symptoms:** _____

5) **Diagnosis:** _____

6) **Seizures:** Type: _____

7) **Medications:** _____ **Dosage:** _____

8) **Immunization History:** **1st** **2nd** **3rd** **Booster** **Booster**

DPT/DTaP/DT					
Td (tetanus)					
MMR					
Pneumovax					
Influenza					
Hepatitis Vaccine					
HiB					
Comvax					
Polio	OPV				
	IPV				
Varicella					
COVID					
Other					

*Indicate if medical or religious contraindications are present

9) **History of Chronic Medical Problems:** _____

10) **Vitals:** Height: _____ in Weight: _____ lbs B/P: _____
 Temp: _____ Pulse: _____ Resp: _____

11) **Vision Screening:** _____ **Hearing Screening:** _____

PHYSICAL EXAM	NORMAL	FINDINGS
Head		
Skin		
Ears		
Neuro		
Nose		
Throat		
Mouth		
Neck		
Chest		
Heart		
Lung		
Abdomen		
Genitalia		
Rectum		
Extremities		
Back		

Are there any problems with locomotion or coordination? _____

Explain: _____

Is there any evidence of scoliosis, kyphosis, or unequal leg length? Yes No

Explain: _____

C-Spine films (recommended for individuals with Down's Syndrome)

Yes No Results/Date: _____

12) **TB Status (Required):**

TB Mantoux Test: _____ (date) / _____ (result) OR

Chest X-Ray if Mantoux is Positive: _____ (date) / _____ (result) OR

Negative Risk Assessment: _____

13) **What do you consider to be the etiology of the developmental disability and when was the diagnosis determined?** _____

14) **Are there any diet restrictions?:** _____ Explain: _____

15) **Optional Testing:**

	date	/	results
PAP Test (females 18 years & older):	_____	/	_____
Mammogram (females 35 years & older):	_____	/	_____
Hemocult (everyone 40 years & older):	_____	/	_____

16) **Additional tests per Physician request:** _____

17) **Optional Lab Work: (date/results)**

CBC: _____ / _____

Urinalysis: _____ / _____

RPR: _____ / _____

Hepatitis B Screen: _____ / _____ (if no proof of immunity or immunization)

(HB Ag): _____ / _____

(Anti-HB): _____ / _____

18) **Atypical behavior patterns and emotional responses:** _____

19) **Participation in activities:** Full participation: _____

Restricted participation: _____

20) **List restrictions and explain (including the use of any appliance or lifting restrictions):** _____

21) Summary of medical data/diagnosis relevant to programs and learning: _____

22) **FREEDOM FROM COMMUNICABLE DISEASE:**

I certify that no communicable disease is evident at the time of this examination.

_____ Yes _____ No

22) Physician has informed individual/guardian of his/her medical status.

Physician Signature

Date

Physician's Name (please print)

Board Policy H-1 Attachment B

**LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
HEALTH HISTORY**

Name: _____ **Sex:** _____ **DOB:** _____

Address: _____

1) **Significant Family History:** (did anyone in your family ever have -- please check all that apply)

_____ Heart Disease	_____ Diabetes	_____ Kidney Problems
_____ Alcoholism	_____ Cancer	_____ Tuberculosis
_____ Epilepsy/Seizures	_____ Neurological	_____ Mental Illness
_____ Other: _____		

2) **Past Medical History:** (please check and include dates if possible)

PART A:

_____ Rheumatic Fever	_____ Arthritis	_____ Asthma
_____ Polio	_____ Tuberculosis	_____ Frequent Colds
_____ Pneumonia	_____ Eczema	_____ Chicken Pox
_____ Strep/Scarlet Fever	_____ Pleurisy	_____ Measles
_____ Meningitis	_____ Diabetes	_____ German Measles
_____ Cancer	_____ Heart Disease	_____ Hepatitis
_____ Tonsillitis	_____ Chronic Ear Infections	
_____ Tobacco Use	___ yes ___ no What Form _____	_____ Quantity Per Day
_____ Other		

PART B: (include dates if possible)

Past Surgery: _____

Past Injuries: _____

Recurring Medical Problems: _____

Past/Present Behavior/Psychiatric Problems: _____

Does Applicant Have Difficulty With: (*if yes, describe below)

Vision: _____ Date of last eye exam: _____ Wears corrective lenses: _____
Hearing: _____ Date of last hearing eval: _____ Wears hearing aide _____
Speech: _____ Receives or has received speech therapy _____
Eating: _____

Ability to control bowels: _____ Ability to control urine: _____

*Describe any difficulty with the above: _____

PART C:

Status of Ambulation:

Independent Semi-Independent Crutches Cane
 Non-Amb Wheelchair Walker Braces

Does individual have any problems in use of arms, hands, legs or walking? If so, explain:

PART D:

Does applicant have/use any of the following?: (please check)

<input type="checkbox"/> Special Bathing Equip	<input type="checkbox"/> Diaper/Depends	<input type="checkbox"/> Eating Devices
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Prosthesis (dentures,etc)
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Urinary Devices	<input type="checkbox"/> Special Shoes
<input type="checkbox"/> Vascular Devices	<input type="checkbox"/> Eye Glasses	<input type="checkbox"/> Ostomy (type)
<input type="checkbox"/> Gastrostomy (type)	<input type="checkbox"/> Respiratory Equip	<input type="checkbox"/> Other: _____

PART E: (Female Applicants)

Is Menstruating? Yes No Periods: Regular Irregular

Special Needs: _____

3) **Nutrition:**

A) Requires Special Diet: Yes No

If yes: Food Supplement: _____

Modified texture / diet: _____

4) **Allergies:**

A) Foods: Yes No If yes, what foods and symptoms: _____

B) Environmental Substances: (include animals if applicable) Yes No

If yes, what and

symptoms: _____

C) Medication Allergies: If yes, what and

symptoms: _____

5) **Skin Problems:** (list any below)

6) **Seizure Disorder:**

Type and Frequency: _____

Age of Onset and Cause (if known): _____

Date of Last Seizure: _____

Other Comments: _____

6) Current Medication Schedule: (include fluoride & vitamin supplements)

TYPE	DOSAGE & FREQUENCY	PURPOSE FOR MEDICATION

8) Physician:

Name: _____ Phone: _____

Address: _____

9) Psychologist/Psychiatrist:

Name: _____ Phone: _____

Address: _____

10) Neurologist Name:

Name: _____ Phone: _____

Address: _____

11) Dentist:

Name: _____ Phone: _____

Address: _____

12) Insurance Information:

Medicaid: _____ Yes _____ No Number: _____

Medicare: _____ Yes _____ No Number: _____

Medicare Part D: _____ Yes _____ No Provider: _____

Number: _____

Other Insurance: _____

Signature Individual/Parent/Guardian/Family Member: _____

Name: _____ Date: _____

Address: _____ Phone: _____

_____ Wk Phone: _____

**Board Policy H-1 Attachment C
LAKE COUNTY BOARD OF DD/DEEPWOOD
DENTAL EXAMINATION AND CHARTING**

Patient Last Name, First	
Responsible Party of Medicaid Number	
Address	
Home Phone	Work Phone
Existing Illnesses, Medications	
Existing Prostheses	Date of Prior Placement
	/
Condition of Ridges, Upper/Lower	Oral Hygiene
	/

Date	Services	Doctor's Signature

Date	Treatment Plan	Date	Treatment Plan

**LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
ANNUAL RESIDENTIAL PHYSICAL EXAMINATION**

1) **NAME:** _____ 2) **DOB:** _____ 3) **SEX:** M ___ F ___

4) **DIAGNOSIS:** _____

5) **ALLERGIES/ADVERSE REACTIONS:** _____

6) **IMMUNIZATION HISTORY:** (Prior 12 months)

dT _____	date/result _____	TB PPD _____	date/result or _____
Pneumovax _____	date/result _____	Chest X-ray _____	date/result _____
Influenza _____	date/result _____	COVID _____	dates _____

7) **SEIZURE:** Yes: _____ No: _____ Type: _____ Frequency: _____

8) **VISION EXAM:** _____ date _____ 9) **HEARING SCREENING:** _____

date

10) **MENSTRUAL HISTORY:** LMP: _____ PAP: _____ date _____

11) **DIET:** _____

12) **SIGNIFICANT PAST MEDICAL / SURGICAL HISTORY:** _____

13) **VITALS:** HT: _____ WT: _____ B/P: _____

Temp: _____ Pulse: _____ Resp: _____

14) **PHYSICAL EXAMINATION:**

	NORMAL	FINDINGS
HEAD		
SKIN		
EARS		
NEURO		
NOSE		
THROAT		
MOUTH		
NECK		
CHEST		
HEART		
LUNG		
ABDOMEN		
GENITALIA		
RECTUM		
EXTREMITIES		
BACK (scoliosis, kyphosis)		

15) **Atypical behavior patterns/emotional responses:** _____

16) **Recurring Medical Problems:** _____

17) **Summary of medical data/diagnosis and recommendations:** _____

18) **Participation in activities:** Full participation: _____ Restricted participation: _____

List restrictions and explain (including the use of any appliance or lifting restrictions): _____

19) **Freedom from communicable disease:**

I certify that no communicable disease is evident at the time of this examination.

_____ Yes _____ No

20) **Physician has informed individual of his/her medical status:**

Signature of Physician

Physician's Name (Please Print)

Date

Address

Phone #

**LAKE COUNTY BOARD OF DD/DEEPWOOD
BROADMOOR SCHOOL 8090 Broadmoor Rd., Mentor, Oh 44060
Preschool – Physical & School Age Update**

Name of Child: _____

Parent/Guardian: _____

DOB: _____

Immunization Record:	Dose 1	Dose 2	Dose 3	Dose 4
DPT DtaP/DT/Td				
Polio (OPV/IPV)				
MMR		XXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXX
Hib				
HEP				XXXXXXXXXXXX
COMVAX				XXXXXXXXXXXX
Other:				

Height: _____ Weight: _____ Teeth (T): _____ (P): _____

Required Testing:

TB Mantoux Test: _____ (date) / _____ (result) OR

Chest X-Ray if Mantoux is Positive: _____ (date) / _____ (result) OR

Negative Risk Assessment: _____

HCT: _____ date / _____ result Follow up: Yes _____ No _____

Lead: _____ date / _____ result Follow up: Yes _____ No _____

Vision Screening: Date Done: _____

Distance Acuity	Right:	Left:	
Muscle Balance	Pass:	Fail:	Not Done:
Farsightedness	Pass:	Fail:	Not Done:
Color	Pass:	Fail:	Not Done:
Child Wears Glasses?	Yes:	No:	
Tested with Glasses?	Yes:	No:	
Referral Made?	Yes:	No:	

Hearing Screening: Date Done: _____

Audiometric Results Right Ear	Pass:	Fail:	Not Done:
Audiometric Results Left Ear	Pass:	Fail:	Not Done:
Child Wears Hearing Aid?	Yes:	No:	
Tested with Hearing Aid?	Yes:	No:	
Referral Made:	Yes:	No:	

CONTINUED ON BACK

Name of Child: _____

PHYSICAL EXAMINATION:

	Findings		Findings
Head		Lungs	
Nose		Abdomen	
Mouth		Genitalia	
Throat		Rectum	
Teeth		Extremities	
Neck		Back	
Heart		Skin	

Current Medication(s):

_____	_____
_____	_____
_____	_____
_____	_____

I certify that no communicable disease is evident at the time of this examination and the child is in suitable condition for enrollment in a pre-school program.

 Physician's Signature

 Physician's Name & Address

 Date of Exam

**LAKE COUNTY BOARD OF DD/DEEPWOOD
PRESCHOOL DENTAL EXAMINATION**

Name: _____

Parent/Guardian: _____

D.O.B.: _____ Date of Exam: _____

Oral Hygiene: _____

(T) Teeth:

(P) Teeth:

Treatment:

Recommendations:

Doctor's Signature: _____

**LAKE COUNTY BOARD OF DD/DEEPWOOD
NURSING SERVICES
ANNUAL ADULT SERVICES
PHYSICAL EXAMINATION**

1) **NAME:** _____ 2) **DOB:** _____ 3) **SEX:** M ___ F ___

4) **DIAGNOSIS:** _____

5) **ALLERGIES/ADVERSE REACTIONS:** _____

6) **IMMUNIZATION HISTORY:** (Prior 12 months)

dT _____	date/result _____	TB PPD _____	date/result or _____
Pneumovax _____	date/result _____	Chest X-ray _____	date/result _____
Influenza _____	date/result _____	_____	

7) **SEIZURE:** Yes: _____ No: _____ Type: _____ Frequency: _____

8) **VISION EXAM:** _____ date _____ 9) **HEARING SCREENING:** _____
date _____

10) **MENSTRUAL HISTORY:** LMP: _____ PAP: _____ date _____

11) **DIET:** _____

12) **SIGNIFICANT PAST MEDICAL / SURGICAL HISTORY:** _____

13) **VITALS:** HT: _____ WT: _____ B/P: _____
Temp: _____ Pulse: _____ Resp: _____

14) **PHYSICAL EXAMINATION:**

	NORMAL	FINDINGS
HEAD		
SKIN		
EARS		
NEURO		
NOSE		
THROAT		
MOUTH		
NECK		
CHEST		
HEART		
LUNG		
ABDOMEN		
GENITALIA		
RECTUM		
EXTREMITIES		
BACK (scoliosis, kyphosis)		

Name: _____

15) Atypical behavior patterns/emotional responses: _____

16) Recurring Medical Problems: _____

17) Summary of medical data/diagnosis and recommendations: _____

18) Participation in activities: Full participation: _____ Restricted participation: _____

List restrictions and explain (including the use of any appliance or lifting restrictions): _____

19) Freedom from communicable disease:

I certify that no communicable disease is evident at the time of this examination.

_____ Yes _____ No

20) Physician has informed individual of his/her medical status:

Signature of Physician

Physician's Name (Please Print)

Date

Address

Phone #