**Section 300.APPENDIX D Forms for Day Care in Long-Term Care Facilities**

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| SAMPLE |
|  |  |
| APPLICATION FOR DAY CARE |
| FORM A |  |
|  |  |
| NAME |  | AGE |  | BIRTH DATE |  |
| ADDRESS |  | PHONE |  |
|  |  | SOCIAL SECURITY NUMBER |  |
|  | MEDICARE NUMBER |  |
|  |  |
| WITH WHOM DO YOU LIVE? |  |
|  |  |
| RELATIONSHIP? |  |
|  |  |
| PERSON TO CONTACT IN AN EMERGENCY |  |
|  | ADDRESS |  |
|  | PHONE |  | BUSINESS PHONE |  |
|  |  |
| PHYSICAL LIMITATIONS (please list) | 1. |  |
|  | 2. |  |
|  | 3. |  |
|  | 4. |  |
|  |  |
| SPECIAL PHYSICAL NEEDS (medications during day, special rest periods, etc. please list) |
|  |  |
| 1. |  | 4. |  |  |
| 2. |  | 5. |  |  |
| 3. |  | 6. |  |  |
|  |  |
| MEDICAL PROBLEMS (circle) |
|  |  |
| 1. | diabetic | 8. | hearing |
| 2. | subject to seizures | 9. | eyesight |
| 3. | heart disease | 10. | assistance with meals |
| 4. | dizziness | 11. | any paralysis |
| 5. | urinary control problem | 12. | difficulty in walking |
| 6. | bowel control problem | 13. | periodic confusion |
| 7. | special diet | 14. | allergies (list) |
|  | 15. | others |
| ARE YOU PRESENTLY UNDER A DOCTOR'S CARE? |  |
|  |  |
| NAME AND ADDRESS OF PHYSICIANS |  |
|  |  |
|  |  |
|  |  |
|  |  |
| SPECIAL INTEREST OR HOBBIES |  |
|  |  |
|  |  |
| DAYS ENTERED IN PROGRAMMING |  |
|  |  |
|  | A.M. |  | P.M |  |
| Monday |  |  |  |  |
| Tuesday |  |  |  |  |
| Wednesday |  |  |  |  |
| Thursday |  |  |  |  |
| Friday |  |  |  |  |
|  |  |
| DOYOU HAVE TRANSPORTATION? |  |  |

(Source added at 9 Ill. Reg. 11049, effective July 1, 1985)

|  |  |
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| FORM B | SAMPLE |
| PHYSICIAN PERMISSION FORM |
|  | has applied for admittance to the day care program at |
|  | . Please supply the following information and also give written |
| permission for |  | to participate in the activity program. |
|  |  |
| Physical Limitations |  |
|  |  |
| Degree of activity |  |
|  |  |
|  |  |
|  | Can day care resident be involved in activities outside of the facility |
| (in the community)? |  |
|  |  |
|  | Has |  | been evaluated within the last 30 days |
| and found to be free of communicable and infectious disease? |  |
|  |  |
|  | Medications and/or treatments and diet needed by day care resident during |
| the period of time spent in the facility. |  |
|  |  |
|  |  |
|  |  |
|  | Can day care resident take own medication? |  |
|  | Allergies |  |
|  |  |
|  |  |
| Date: |  | Signature of Physician: |  |

(Source: Added at 9 Ill. Reg. 11049, effective July 1, 1985)