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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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)