APPLICATION FOR ENROLLMENT
DAY CARE FOR ADULTS

Applicant's full name: _____
Address: _____
Phone: _____ DOB: _____ Gender: _____ SSN: _____

INFORMATION ABOUT APPLICANT

Why are you interested in coming to this program? _____
_____
Have you had previous experience in a Day program? ☐ Yes ☐ No
If yes, where and when? _____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced

Present Living Arrangements: ☐ With Spouse ☐ With Relatives ☐ With Non-Relatives
☐ Alone in House or Apartment ☐ Alone in Single Room

Living with Whom: _____ Relationship: _____

Nearest Responsible Relative: _____ Relationship: _____

If living with someone employed, employer: _____

Phone of Employer: _____ Home Phone: _____

Home Address: _____

EMERGENCY CONTACT INFORMATION

Please list the names of two persons who may be contacted in case of emergency:

_____ _____
Name Relationship to Applicant

_____ _____
Address Telephone Number

_____ _____
Name Relationship to Applicant

_____ _____
Address Telephone Number

Name of Physician who
will see you on request: _____ Telephone: _____

Transportation will be provided by: ☐ Relative or Friend: _____
☐ Other: _____

Monthly Schedule of Attendance:

WEEK 1	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
WEEK 2	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival Time:					
Departure Time:					
WEEK 3	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival Time:					
Departure Time:					
WEEK 4	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival Time:					
Departure Time:					
WEEK 5	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival Time:					
Departure Time:					

Special dietary needs, if any: _____
Attach a copy of the doctor's orders if on a therapeutic diet

Supportive devices used by applicant:
☐ Cane ☐ Walker ☐ Wheelchair ☐ Hearing Aid ☐ Dentures
☐ Eyeglasses/contacts ☐ Other, please list: _____

ADVANCE DIRECTIVE NOTIFICATION

- ☐ My family member does not require a Power of Attorney (POA), may make his/her own medical or other decisions, and may sign for his/herself legally.
- ☐ My family member has a POA or legal guardian:
  Name and number of POA/Guardian: _____
- ☐ My family member has an advance directive
  - ☐ I will provide the day program with an original copy.
- ☐ My family does not have an advance directive.
  - ☐ I would like information on how to obtain an advance directive.
  - ☐ My family member does not want an advance directive.
- ☐ My family member has a DNR order. ☐ I will provide the day program with an original copy.

The day care program's policies have been explained to me and I have been given a copy of them and agree to abide by them. If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary.

Applicant Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

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MEDICINE LIST

I hereby authorize the personnel of the Ruth Sheets Adult Care Center to administer the medicine(s) listed below. In doing so, I hereby release said program, its officers, staff and personnel, from any and all liability that might arise as a result of the medication being administered and hereby waive any action which I may have as a result of the medication being administered. I will be notified when the medicine supply is low. Furthermore, I release the fore said from any and all liability that might arise as a result of said medication not being administered because the supply was not replenished.

Participant's Name: _____

Name Of Medication	Dosage	Frequency	Notes

I give my permission for participant to take the following over-the-counter medication if requested (to be provided to reduce pain or fever, as directed on the bottle):

_____ Acetaminophen (500mg) _____ Ibuprofen (200mg)

Allergies: _____

Medication Policy:

State regulations prohibit administering any medication not in the original container from the doctor or pharmacy. North Carolina Adult Day Care Standards for Certification state that medications kept by the program shall be in containers in which they were dispensed from the pharmacy. The containers shall be clearly labeled with the participant's full name, the name and strength of the medicine, and dosage and instructions for administration. Only medication that meets these stated criteria will be given. Most pharmacies will give two containers if asked. Pills brought to the center in pill boxes or other containers not meeting the above description cannot be given.

_____ _____

SIGNATURE OF PARTICIPANT/GUARDIAN DATE

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To be prepared for the emergencies that can and do happen, we need a complete and accurate list of all medications taken either at the Center or at home by the participant. This will provide the rescue squad with the vital medical information that is necessary for them to administer proper treatment in an emergency. It is important that the staff at the Sheets Adult Care Center be given, in writing, any changes in medication in order to keep our records current. Please state the Hospital of your choice; we will honor this whenever possible.

HOSPITAL PREFERRED: _____

Having this information on hand will save valuable time in the event of an emergency.
Please complete the following form and return it with your application

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby authorize the Sheets Adult Care Center to provide medical care from any licensed medical practitioner deemed necessary, if such emergency care is needed by me.

I understand that emergency medical care will be provided during the operating hours of the Center and notification to a relative or responsible person will be made as soon as possible.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Director Date

_____ _____
Witness Date

MEDICAL INFORMATION RELEASE

I hereby authorize the Ruth Sheets Adult Care Center to receive my medical information provided by my physician as requested by the Policy and Application forms of the Center. This consent for the release of medical information is authorized only for the duration of my enrollment in the Ruth Sheets Adult Care Center.

DATE:_____ _____
SIGNATURE OF PARTICIPANT/GUARDIAN

_____
DIRECTOR/STAFF

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AUTHORIZATION FOR PHOTOGRAPHS & VIDEO

I authorize the use of photographs and / or video taken of me during Center activities to be used for purposes of information and public relations regarding the Ruth Sheets Adult Care Center. The use of photographs/video of me may be included in brochures, websites, and social media for the Ruth Sheets Adult Care Center

DATE:_____ _____
SIGNATURE OF PARTICIPANT

_____
WITNESS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I_____ hereby authorize the Ruth Sheets Adult Care Center to release confidential information on me to_____(911 etc.) When deemed necessary in order to maintain or to improve my well-being. This consent for the release of confidential information is authorized only for the duration of my enrollment in the Ruth Sheets Adult Care Center.

DATE:_____ _____
SIGNATURE OF PARTICIPANT/GUARDIAN

_____
DIRECTOR/STAFF

CONFIDENTIALITY

All information in participants file will be used only for emergency needs and for staff, volunteers, and interns to aid in the proper care of the participant.

Information that is needed only to assist in the care of the participant will be released.

All information will be kept confidential and shared with no other agency or organization without written consent from participant or family member.

_____ _____
DATE SIGNATURE OF PARTICIPANT/GUARDIAN

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SOCIAL HISTORY FORM

ANSWERS TO THE FOLLOWING QUESTIONS HELPS THE STAFF KNOW YOUR LOVED ONE BETTER. THE INFORMATION HELPS US GUIDE CONVERSATION WHEN YOUR LOVED ONE IS TRYING TO SHARE HIS/HER BACK ROUND WITH THE STAFF AND OTHER PARTICIPANTS.

FULL NAME:_____SEX: M F

DATE OF BIRTH:_____/___/_____ PLACE OF BIRTH:_____

RELIGIOUS PREFERENCE:_____

FATHER'S NAME:_____
STILL LIVING: YES NO IF NOT INDICATE DATE OF DEATH:___/___/____

MOTHER'S NAME: _____
STILL LIVING: YES NO IF NOT INDICATE DATE OF DEATH:___/___/____

NUMBER OF SIBLINGS: _____

NAMES:_____
_____
_____

MARRIAGES: PLEASE GIVE NAMES AND INDICATE WHETHER LIVING OR DATE OF DEATH.

_____
_____

NAMES OF CHILDREN: PLEASE INDICATE ORDER AND WHERE THEY ARE LIVING OR WHEN THEY DIED.

_____
_____
_____
_____

NAMES OF GRANDCHILDREN: _____
_____
_____
_____

NAMES OF GREAT GRANDCHILDREN: _____
_____
_____
_____

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PLACES OF EMPLOYMENT: (Dates and duties if possible) _____

INTERESTED PLACES TRAVELED: _____

SPECIAL PETS: _____

EDUCATION: (include degrees, diplomas, certificates or other special training)

FAVORITE ACTIVITIES: (hobbies, favorite book, etc.) _____

SIGNIFICANT LOSSES: (death of spouse, child, friend, job, etc.) _____

OTHER STORIES OR EVENTS YOU WOULD LIKE TO SHARE:_____

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APPLICANT MEDICAL INFORMATION

The individual listed below desires or has enrolled in a Day Program for Adults. Supervision is provided during the day for disabled and elderly adults in a protective setting approved by the State Department of Health and Human Resources, Division of Aging and Adult Services to provide for personal care; to promote social, physical, and emotional well-being; and to offer opportunities for companionship, self-education and other leisure time activities.

In order to protect both the applicant and other participants, and in the event of an emergency it is necessary that we have medical information on each person. This information will assist the Day Activity personnel in working with this person.

Patient's Name and DOB: _____ Most Recent Date Seen by a Doctor: _____

Blood Pressure: _____ Pulse/Respiration: _____/_____ Weight: _____

(Optional) TB Test Results: □ Positive □ Negative Date of Test: _____

PHYSICAL HEALTH STATUS:	**NO**	**YES**	**If Yes, Please Comment**
Allergies, Allergic Reactions	□	□	_____
Anemia	□	□	_____
Arthritis, Rheumatism	□	□	_____
Asthma	□	□	_____
Circulatory Problems	□	□	_____
CVA, TIA's, Stroke (Specify)	□	□	_____
Diabetes	□	□	_____
Edema, Swelling	□	□	_____
Emphysema, Chronic Bronchitis	□	□	_____
Gastro-Intestinal Problems, Ulcers	□	□	_____
Heart Condition	□	□	_____
Hepatitis, HIV (Specify)	□	□	_____
High Blood Pressure	□	□	_____
Parkinson's	□	□	_____
Renal (Kidney) Problems	□	□	_____
Seizure Disorder	□	□	_____
Skin Disorders	□	□	_____
Tuberculosis	□	□	_____
UTI's (History of)	□	□	_____
Incontinence	□	□	Bladder □ Bowel □ _____
Other	□	□	_____

Primary Diagnosis: _____ Secondary Diagnosis: _____

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PHYSICAL HEALTH STATUS

□ Malnourishment	□ Change in Bowel Habits	□ Shortness of Breath	□ Lumps
□ Blood in Urine	□ Dizziness	□ Persistent Cough	□ Hearing
□ Vision	□ Severe Headaches	□ Sudden Weight Loss	□ Vomiting
□ Severe Chest Pain	□ Unsteady Gait	□ History of Falls	□ Other

MENTAL HEALTH STATUS:

Organic Brain Damage: □Yes □No Arteriosclerosis: □Yes □No Personality Disorders: □Yes □No

Other: _____

□ Loss of Appetite	□ Hallucinations	□ Orientation Problems	□ Insomnia	□ Delusions
□ Confusion	□ Hypochondria	□ Distortion in Thinking	□ Feeling of Worthlessness	
□ Alcohol Abuser	□ Drug Abuser	□ Loss of Interest	□ Hazardous Behaviors	
□ Suspiciousness	□ Memory Loss	□ Impaired Judgment	□ Wanders	

Medicine Patient is taking:

Medicine	Dosage	Frequency

GENERAL INFORMATION:

Does this person require constant supervision to ensure harm is not done to self, others or property? □ Yes □ No

Will this person wander off if not closely attended? □ Yes □ No

Can this person do light exercises from a sitting position, such as leg lifts, arm lifts, etc? □ Yes □ No

Do you recommend any special type of activities for this client, such as group activities, craft activities, physical exercise, training in self-care? □ Yes □ No

Is a special diet or other special regimen required for this patient? □ Yes □ No (If yes, please attach or describe)

_____

Please comment on any physical, mental, or emotional condition apparent from your knowledge of the above named person that might need further explanation or might affect other participants.

_____

I certify that I have today reviewed the health history and examined this person and find him/her physically able to participate in an adult day care activity program.

Signed: _____ Date: _____

MD, PA, or Nurse Practitioner

Address: _____ Phone: _____

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