



**RUTH SHEETS ADULT CARE CENTER
APPLICATION FOR ENROLLMENT
DAY CARE FOR ADULTS**

INFORMATION ABOUT APPLICANT

Applicant's full name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

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:

1. _____
Name Relationship to Applicant

_____ Telephone Number
Address

2. _____
Name Relationship to Applicant

_____ Telephone Number
Address

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: _____

MEDICINE & 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.

I hereby authorize the personnel of the Ruth Sheets Adult Care Center to administer medicine(s) as prescribed and/or ordered by my physician. 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 foresaid from any and all liability that might arise as a result of said medication not being administered because the supply was not replenished. In addition, I agree to provide the personnel of the Ruth Sheets Adult Care Center with appropriate documentation for any and all changes in medication, treatment, condition. This may include facility discharge information and updated doctor's orders.

Allergies: _____

SIGNATURE OF PARTICIPANT/GUARDIAN

DATE

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: _____

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 PARTICIPANT/GUARDIAN

DATE

SIGNATURE OF DIRECTOR/STAFF

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

SIGNATURE OF DIRECTOR/STAFF

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/GUARDIAN

SIGNATURE OF DIRECTOR/STAFF

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

SIGNATURE OF 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

SIGNATURE OF DIRECTOR/STAFF

POLICY ACCEPTANCE

I have received a copy of and I have read the Ruth Sheets Adult Care Center’s Policy and participation requirements, and I agree to the terms stated within.

DATE: _____

SIGNATURE OF PARTICIPANT/GUARDIAN

SIGNATURE OF DIRECTOR/STAFF

SOCIAL HISTORY FORM

Answers to the following help the staff know your loved one better. The information helps us guide conversation when your loved one is trying to share his/her background with the staff and other participants.

Nickname or other preferred name: _____ DOB: ____/____/____

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: ____/____/____

Siblings: Please give names and indicate whether living or date of death.

Marriages: Please give names and indicate whether living or date of death.

Children, Grandchildren, and Great Grandchildren: Please give names and indicate whether living or date of death.

Additional Information such as Military Service, Employment, Education, Special Pets, Favorite Stories or Activities, and/or Places Traveled:

TO BE FILLED OUT BY THE DOCTOR

RUTH SHEETS ADULT CARE CENTER - 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: _____

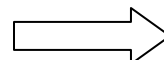
Blood Pressure: _____ Pulse/Respiration: _____/_____ Weight: _____

(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: _____

PLEASE COMPLETE BOTH SIDES



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

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.

PLEASE ATTACH MEDICATION LIST FROM DOCTOR'S OFFICE

OVER THE COUNTER MEDICATIONS (TO BE GIVEN AS DIRECTED ON THE BOTTLE):

_____ Acetaminophen (500mg)

_____ Ibuprofen (200mg)

Other: _____

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: _____
MD, PA, or Nurse Practitioner

Date: _____

Address: _____

Phone: _____