**Section 350.APPENDIX D...Forms For Day Care in Long-Term Care Facilities**

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| APPENDIX D |
|  |  |  | SAMPLE |
| Forms For Day Care in Long-Term Care Facilities |
|  |  |  |  |
| FORM A: |
|  |  |  |  |
| APPLICATION FOR DAY CARE |
|  |  |  |  |
| 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 |  |  |  |  |
|  |
| DO YOU HAVE TRANSPORTATION? |  |

|  |  |
| --- | --- |
|  | SAMPLE |
| FORM B: |
|  |
| 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. 10876, effective July 1, 1985)