FUTURES COMMUNITY SUPPORT SERVICES, INC.
ANNUAL PHYSICAL FORM
6400 Regulations

Name: ______________________________ Date:____________________

*** If the person attends ATF ***
Please make sure a copy is forwarded to the day program and county supports coordinator.

6400.141. INDIVIDUAL PHYSICAL EXAMINATION

6400.141.(c) (1) Review of previous medical history.

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6400.141.(c) (2) General Physical Examination

6400.141.(c) (3) Immunization for individuals 18 years of age or older as recommended by the United States Public Health Services.

DT Yes _________ No ___________ Date: ___________

RECOMBIVAX Yes _________ No ___________ Date: ___________

Carrier no Antibodies ____
____

6400.141.(c) (4) Vision and hearing screening for individuals 18 years or older recommended by the physician.

VISION SCREENING:

Distant Vision: Without Glasses Right: ___________ Left: ___________

Without Glasses Right:___________ Left: ___________

HEARING SCREENING:
Ordinary Conversation: Right ___________/15 Left ____________/15

Results: ____
____

6400.141.(c) (5) Immunizations and screening tests for individuals 17 years of age or younger, as recommended by the Standards of Child Health Care of the American Pediatrics.

Can be done on above regulation (3) & (4).

6400.141. (c) (6) Tuberculin skin testing by Mantoux method with negativity results every 2 years for individuals 1 year of age or older; or if tuberculin skin test is positive, an initial x-ray with results noted.

TB Mantoux Method: Yes: _________ No: _________ Date: ____________________

Results: ____

____

6400.141.(c) (7) A Gynecological examination including a breast examination and a Pap test for women 18 years of age or older, unless there is documentation from a licensed physician recommending no or less frequent gynecological examinations.

Gynecological Exam: Yes: _________ No: _________ Date: ____________

Results: ____

____

6400.141.(c) (8) A mammogram for women at least every 2 years for women 40 through 49 years of age and at least every year for women 50 years of age or older.

Mammogram: Yes: _________ No: _________ Date: _________

Results: ____

____

6400.141(c) .(9) A prostate examination for men 40 years of age or older.

Prostate Exam: Yes: _________ No: _________ Date: ____________

Results: ____

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6400.141.(c) (10) Specific precautions that must be taken if the individual has a communicable disease to prevent spread of the disease to other individuals.

Communicable Disease: Yes: _________ No: _________ Date: ____________

Precautions: ____

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6400.141.(c) (11) An assessment of the individual's health maintenance needs, medication regimen and the need for blood work at recommended intervals.

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6400.141.(c) (12) Physical limitations of the individuals.

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6400.141.(c) (13) Allergies or contraindicated medications.

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6400.141.(c) (14) Medical information pertinent to diagnosis and treatment in case of emergency.

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6400.141 (c) (15) Special instructions for the individual's diet.

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6400. 141 (b)
Physician Signature: __________________________________ Date: ___________

PHYSICIAN RECOMMENDS OTC LIST

Individual's Name: ________________________________

Program: ____ Date:____________

Over-the-Counter drugs individual should use for the following problems:

Date D/C and initial

_____1. Upset Stomach/Thrown Up: ____

____

_____2. Diarrhea:____

____

_____3. Cold/Runny Nose: ____

____

_____4. Cough: ____

____

_____5. Fever: ____

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_____6. Constipation: ____

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_____7. Headache: ____

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_____8. Minor Aches and Pains: ____

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_____9. Menstrual Cramps: ____

____

_____10. Other: ____

(Please see reverse side for additional OTC Medications)

____ May Substitute with generic. ____

____

____

Physician's Signature

*Refer to OTC equivalent reference list.

Over-The-Counter drugs should be used for the following problems:

Date D/C
and initial

_____11. Other Conditions (please specify): ______

____

____

_____ 12. Other Conditions (please specify): ______

____

____

_____13. Other Conditions (please specify): ____

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_____14. Other Conditions (please specify): ____ __

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_____15.Other Conditions (please specify): ____

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****** Reminder: Print and attach the MA 51 form to this document******