

FUTURES COMMUNITY SUPPORT SERVICES, INC.
ANNUAL PHYSICAL FORM
6500 Regulations (Family Living)

Name: _____

Date: _____

*** If the person attends ATF ***

Please make sure a copy is forwarded to the day program and county supports coordinator.

6500.121. INDIVIDUAL PHYSICAL EXAMINATION

6500.121.(c) (1) Review of previous medical history.

6500.121.(c) (2) General Physical Examination

6500.121.(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 _____

6500.121.(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: _____

6500.121.(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).

6500.121. (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: _____

6500.121.(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: _____

6500.121.(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: _____

6500.121(c) (9) A prostate examination for men 40 years of age or older.

Prostate Exam: Yes: _____ No: _____ Date: _____

Results: _____

6500.121.(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: _____

6500.121.(c) (11) An assessment of the individual's health maintenance needs, medication regimen and the need for blood work at recommended intervals.

6500.121.(c) (12) Physical limitations of the individuals.

6500.121.(c) (13) Allergies or contraindicated medications.

6500.121.(c) (14) Medical information pertinent to diagnosis and treatment in case of emergency.

6500.121 (c) (15) Special instructions for the individual's diet.

6500.121 (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: _____

____ 6. Constipation: _____

____ 7. Headache: _____

____ 8. Minor Aches and Pains: _____

____ 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): _____

____ 14. Other Conditions (please specify): _____

____ 15. Other Conditions (please specify): _____

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