PARTICIPANT MEDICAL CLEARANCE FORM

Please check applicable center:

☐ Encinitas Center | 335 Saxony Road | Encinitas, CA 92024 | Ph. 760-635-1895 | Fax: 760-436-0949
☐ Hillcrest Center | 3686 Fourth Avenue | San Diego, CA 92103 | Ph. 619-543-4705 | Fax: 619-543-5145
☐ Town Square® | 2765 Main St. Ste. A, Chula Vista, CA 91911 | Ph. 619-420-1703 | Fax: 619-344-8089

Date: _________________

Participant Name: __________________________________ DOB: ____________________

Please confirm the above-named participant is medically cleared to return to the Adult Day Program or Adult Day Healthcare Center, indicated above, by completing all requested information below, signing and dating the form and faxing the form to the appropriate center.

The above-named participant is medically cleared and approved to resume attendance at the center designated above. ☐ Yes ☐ No

New diagnosis(es) or changes in condition? ☐ Yes ☐ No

If yes, please list/specify here: ____

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Medication updates/changes? ☐ Yes ☐ No

If yes, please list medication information below or attach a current medication list.

Is a current medication list attached? ☐ Yes ☐ No (**Include discontinued date, if applicable.)*

Medication	Dosage	Route	Frequency	Date Discontinued*

Newly developed urinary or bowel incontinence? ☐ Yes ☐ No

If yes, please specify the type of incontinence: ____________________________________

Physical limitations? ☐ Yes ☐ No

If yes, please specify the limitations here. Please note, the participant must be able to bear weight, pivot/turn and transfer with minimal assistance: ______________________________

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Diet updates/changes? ☐ Yes ☐ No

If yes, please complete the information below for the participant's current diet orders*:

*(*Center may deviate from NCS diet order up to two times per month for special occasions.)*

Diet: ☐ Regular ☐ NAS ☐ NCS* ☐ CCHO/CCD ☐ CKD ☐ Other: _______________
Diet Texture: ☐ Regular ☐ Chopped ☐ Pureed ☐ Mechanical Soft ☐ Other: _______________ ☐ Thickened liquids (Indicate consistency: ______________________)
Known food restrictions? ☐ Yes ☐ No If Yes, please specify: ________________________________

Additional information and/or comments:

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________________________ ________________________ ________
Name of Physician Signature Date

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Physician's Telephone Number