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
_____ _____
Address Telephone Number

2. _____ _____
Name Relationship to Applicant
_____ _____
Address Telephone Number

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: _____

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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

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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:

_____
_____
_____
_____
_____
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_____
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_____

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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		__	__	_____
Covid-19		__	__	_____
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	__	__	_____

Primary Diagnosis: _____ Secondary Diagnosis: _____

PLEASE COMPLETE ALL 3 PAGES

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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 __ Vertigo

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 COMPLETE ALL 3 PAGES

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PLEASE ATTACH CURRENT 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: _____ Date: _____

MD, PA, or Nurse Practitioner

Address: _____ Phone: _____

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