Health Statement

Name: ____ Date of Birth: ___________________
Physician or N.P./P.A.: ____
Address: ____
Office phone: ____ Fax: _______________________________

PHYSICIAN ORDER FORM

DISEASES/ CHRONIC CONDITIONS:

ALLERGIES: (If YES, please list or write none/NKA) Reaction:	**ACTIVITY LEVEL/RESTRICTIONS:**
DIET:	**ADAPTIVE DEVICES**: Cane: _____ Walker: _______ Wheelchair: Other:

Mini Mental Status:

MEDICATIONS/TREATMENTS/PROVIDER ATTESTATION:

<table>
<tr><td colspan="2">List all medications, dosage, route and frequency: (If additional sheet is needed it must be signed)</td></tr>
<tr><td colspan="2">PRN while in attendance at Compass Point Senior Enrichment Center:

______Tylenol 325 mg2 tabs PO Q4 H-moderate pain _____ Tylenol 500 mg 2 tabs PO Q4 H-moderate pain

Other: ____

__________ (Please initial) To promote independence, participant may bring medication to the Day Center and self-administer under supervision of staff.</td></tr>
<tr><td colspan="2">**** Provider confirms that participant is suitable for attending and participating in the Compass Point Enrichment Center Day Program.</td></tr>
<tr><td>Signature of Physician:</td><td>Date:</td></tr>
<tr><td colspan="2">Please Print Name of Physician:</td></tr>
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