**Medical History and Medical Clearance Form Which Must Be**

**Completed by Applicant’s Physician and**

**Included with the Housing Application**

Doctor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply. Does the patient have a history of:

 Asthma Cancer Cardiac disease Diabetes Hypertension Psychiatric disorder Epilepsy

Check the symptoms

* Check the symptoms that patient is currently experiencing, if any:

 Chest pain Respiratory Cardiac disease Cardiovascular Hematological Lymphatic Neurological Psychiatric Gastrointestinal Genitourinary Weight gain Weight loss Musculoskeletal

* Does the patient have any medication allergies?

 Yes No Not Sure

* Have you had the Hepatitis B vaccination \*

 Yes No

* Immunity information (please note: this information must be provided prior acceptance )
* Chicken Pox (Varicella): IMMUNE NOT IMMUNE
* Measles: IMMUNE NOT IMMUNE

List any Allergies:

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |

The Joan Valentine House is a licensed residential healthcare facility and cannot provide the level of care provided by a nursing home.

Agnie’s House is a supportive apartment program and does not provide the level of service of a Residential Healthcare Facility.

|  |  |  |
| --- | --- | --- |
| Criteria | Yes | No\* |
| Patient is able to ambulate without assistance |  |  |
| Patient is free of communicable diseases |  |  |
| Patient is clear of any lice/nits and has been examined |  |  |
| Patient is capable of taking care of his/her own hygiene |  |  |
| Patient is capable of doing his/her own laundry |  |  |
| Patient is able to climb 16 stairs unassisted |  |  |
| If applicable: Patient can check his own blood glucose level and administer insulin |  |  |
|  |  |  |

*Must be completed and signed by the physician.*

This is to certify that I Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have examined,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and completed the medical clearance form on:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_