Stepping Stones Master Medical Form

Nurse 513-559-2452

TO BE COMPLETED , SIGNED AND DATED ONLY BY PHYSICIAN OR CNP

Please return by:

Mail: Client Services
Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243
PDF:
jeannie.ludwig@steppingstonesohio.org

Fax: 1-877-913-1293

(PLEASE PRINT)

Participant's Name ____
Birth Date ___/___/___ Sex ___ Height ____ Weight ____ BP _____ Temp ____ Pulse____ Resp. _____
Physician Name ____
Phone (_______) ___________________ Fax (_______) _________________
Diagnosis ____

____

PAST MEDICAL AND PHYSICAL HISTORY

___ ADD
___ ADHD
___ Arthritis
___ Aspergers
___ Auditory Impairment (circle correct side)
    Hearing Aid left right
    P.E. Tubes left right
    Cochlear Implant left right
___ Autism Spectrum Disorder
___ Brain Injury
___ Cardiac Diagnosis
___ Cerebral Palsy
___ Circulatory Disorder
    ___ PVD
    ___ Atherosclerosis
    ___ Other ____________________________
___ Communicable Disease
    Describe ____________________________
___ Dermatological Condition
    Describe ____________________________
___ Developmental Disability
___ Down Syndrome
___ Hydrocephalus
___ Learning Disability
___ Microcephalus

___ Mental Health Disorder
    ___Bi-Polar
    ___ OCD
    ___ Schizophrenia
    ___ Other______________________________
___ Paraplegia
___ Prader-Willi Syndrome
___ Quadriplegia
___ Respiratory Disorder
    ___ Asthma ___Inhaler ___ Nebulizer ___ C-Pap
    ___ COPD
    ___ Tracheostomy
___ Scoliosis
___ Sensory Integration Disorder
___ Seizure Disorder
    Type ______________________
___ Spina Bifida
___ Shunt
    Type______________________________
    Location____________________________
___ Uses Wheelchair
___ Visual Impairment
    ___ Glasses ___ Contacts

☐ **NOT APPLICABLE**

ALLERGIES (food, environmental, seasonal, medications, insects, other)

Allergy	Signs & Symptoms	Treatment

☐ **NOT APPLICABLE**

EPI-PEN (MUST BE PROVIDED BY PARENT/GUARDIAN)

Administered for SEVERE allergic reactions to ______________________________Dosage ____________________

If Epi-Pen is administered, 911 will always be called

☐ **NOT APPLICABLE**

SEIZURE TREATMENT PROTOCOL

(Treatment order and **EMERGENCY PLAN**)

Treatment Order Date ____/____/____
Treatment: ___ VNS (vagal nerve stimulator) magnet for seizure>____ minutes
___ Versed (Nasal Spray) _________________PRN for seizure > ____ minutes
___ Diastat (Rectal Gel) ________mg rectally PRN for seizure> ____ minutes
Comments____

____

If Diastat is administered, 911 will always be called

Physician Name (print)____________________________ Signature ______________________ Date ___/___/___

Participant Name ________________________________ **Date of Birth** ___/___/___

☐ DOES NOT TAKE PRESCRIPTION DRUGS

PRESCRIPTION/OTC DRUGS

Please attach a signed and dated printout of any medications taken by the participant.

Due to state regulations, a doctor's signature is needed for the following PRN's:

___ **Sunscreen SPF 30 -** Apply before exposure and as needed
___ **Acetaminophen -** Follow directions on packaging as needed
___ **Ibuprofen -** Follow directions on packaging as needed

Possible Side Effects: ____

IMMUNIZATIONS

Please attach a signed and dated printout of immunizations.

☐ NOT APPLICABLE

TB TEST/CHEST X-RAY*

TB Skin Test Date ___/___/___ Type: (circle one) PPD Mantoux Result: ____________________
Chest x-ray Date ___/___/___ Findings:____

*not required for admission

☐ NOT APPLICABLE

PERSONS WITH DOWN SYNDROME

___ Negative Cervical x-ray for Atlantoaxial Instability.*
X-ray date ___/___/___ ____ Positive ____ Negative for clinical symptoms of Atlantoalial Instability

*not required for admission

☐ NOT APPLICABLE

TOILETING INSTRUCTIONS

Colostomy Yes _____ No _____
Ileostomy Yes _____ No _____
Collection Bag Yes _____ No _____ Type ___________________________
Catheter Yes _____ No _____ Type ___________________________
How Often____

ACTIVITY RESTRICTIONS

Is the individual restricted from participation in any activities (swimming, hiking, fitness activities, etc.)
Please explain: ____
____
____

Please check if the individual is subject to the following:

_____ Sunburn
_____ Frostbite
_____ Sore Throat
_____ Skin Rash
_____ Hypertension
_____ Vaginal Infections
_____ Menstrual Problems
_____ Frequent Colds
_____ Bronchitis
_____ Pneumonia
_____ Hernia
_____ Heart Defect/Disease
_____ Dizziness/Fainting Spells
_____ Ear Infection
_____ Sinus Infection
_____ Must Not Get Water In Ears
_____ Bleeding Disorders
_____ Decubiti/Skin Breakdown
_____Urinary Infections
_____ Constipation
_____ Diarrhea
_____ Nausea/Vomiting
_____ Stay Out of Water
_____ MRSA/VRE

Physician Name (print)____________________ **Signature** ____________________ **Date** ___/___/___

Participant Name ________________________________ **Date of Birth** ___/___/___

DIETARY NEEDS

Regular Diet (No Restrictions) Yes_____

If restrictions, please fill out below :

Is participant NPO at all times: Yes _____ No ____

Type of tube: Gastrostomy _____ Jejunostomy ______ Nasogastric _____

Type of formula: ____________________________ Amount __________________Water Amount __________________

Time(s): ___________________________Method of administration: (will be gravity flow unless stipulated)

____

____

Special Precautions:____

____

☐ **NOT APPLICABLE**

DIABETIC NEEDS

INSULIN SLIDING SCALE

____

____

____

____

____

Diet Requirements: (be specific) ____

____

Insulin: ___yes ___ no Type _______________________

Glucagon: ___ yes ___ no Protocol For Administration ____________________________

Treatment for Hypoglycemia: ____

Physician Name (print)_____________________________ **Signature** ___________________________ **Date** ___/___/___