Stepping Stones Master Medical Form

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

(PLEASE PRINT)

Participant's Name _____

Birth Date ___/___/___ Sex ___ Height ____ Weight ____ BP _____ Temp ____ Pulse____ Resp. _____

Physician Name _____

Phone (_____) _____ Fax (_____) _____

Diagnosis _____

_____

Please return by:

Mail: Client Services
Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243

PDF:
jeannie.ludwig@steppingstonesohio.org

Fax: 1-877-913-1293

COMPLETE MEDICAL AND PHYSICAL HISTORY

(check all that apply)

___ 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
___ Bleeding Disorder
___ Brain Injury
___ Cardiac Diagnosis
___ Cerebral Palsy
___ Circulatory Disorder
___ PVD
___ Atherosclerosis
___ Other _____
___ Communicable Disease
Describe _____
___ Dermatological Condition
Describe _____
___ Developmental Disability
___ Down Syndrome
___ Gastrointestinal Conditions:
___ Celiac Disease ___ Crohn's Disease
___ Other _____
___ Hydrocephalus
___ Learning Disability
___ Microcephalus
___ Mental Health Disorder
___Bi-Polar
___ OCD
___ Schizophrenia
___ Other_____
___ Paraplegia
___ Prader-Willi Syndrome
___ Quadriplegia
___ Respiratory Disorder
___ Asthma ___Inhaler ___ Nebulizer ___ C-Pap/Bi-PAP
___ COPD ___Oxygen
___ Tracheostomy
___ Scoliosis
___ Sensory Processing Disorder
___ Seizure Disorder
Type _____
___ Spina Bifida
___ Shunt
Type_____
Location_____
___ Uses Wheelchair ____Manual____Electric
___ Visual Impairment
___ Glasses ___ Contacts

Additional Diagnosis: _____
_____
_____
_____

ALLERGIES

☐ **NOT APPLICABLE**

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

Allergy	Signs & Symptoms	Treatment

EPI-PEN

☐ **NOT APPLICABLE**

(MUST BE PROVIDED BY PARENT/GUARDIAN)

Administered for SEVERE allergic reactions to _____Dosage _____

If Epi-Pen 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

ATTACH CURRENT MEDICATION RECORD (must be signed and dated by medical provider)

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

___ **Acetaminophen** - Follow directions on packaging as needed
___ **Ibuprofen** - Follow directions on packaging as needed
___ **Additional PRN Medication** _____
___ **Additional PRN Medication** _____
___ **Additional PRN Medication** _____

IMMUNIZATIONS

Please attach a signed and dated printout of immunizations.

☐ NOT APPLICABLE

SEIZURE TREATMENT PROTOCOL

(Treatment order and **EMERGENCY PLAN**)

Treatment Order Date ____/____/____
Treatment: ___ VNS (vagal nerve stimulator) magnet for seizure>____ minutes
___ Versed/Nayzilam (nasal midazolam) _____PRN for seizure > ____ minutes
___ Valtoco (nasal midazolam) _____ PRN for seizure > ____ minutes
___ Diastat (Rectal Gel) _____mg rectally PRN for seizure> ____ minutes
Other Medication: _____ (please specify)

_____ No Emergency Medication Prescribed

Comments_____

☐ 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_____

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

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

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

DIETARY NEEDS

Dietary Restrictions **Yes**_____ **No**_____

If Yes, 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)
_____
_____
Food Allergy: _____
_____
Special Precautions:_____
_____

☐ **NOT APPLICABLE**

DIABETIC NEEDS

INSULIN SLIDING SCALE
_____
_____
_____
_____
_____

Diet Requirements: (be specific) _____
_____
Insulin: ___yes ___ no Type _____
Daily Dosages/Bolus/Basal: _____
_____
_____
Detailed Orders: _____
_____
_____
Glucagon: ___ yes ___ no Protocol For Administration _____
Treatment for Hypoglycemia: _____

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