



Friendship Ventures Metro (952) 852-0101
 10509 108th St. NW Fax (952) 852-0123
 Annandale, MN 55302 Local (320) 274-8376
fv@friendshipventures.org

FOR OFFICE USE ONLY:
 Date Rec'd. _____
 Session _____

HEALTH HISTORY

This form must be completed by the caregiver and be received in our office with the Application Parts 1 (A&B) and 2 (A&B) for registration in any Friendship Ventures service.

Name _____ Date of Birth ____/____/____ Male ____ Female ____
Last First Middle Initial

Doctor: _____ (____) _____
Name Address City/State/Zip Phone

PLEASE SEND PHOTOCOPY OF ALL INSURANCE, MA & MEDICARE CARDS

MA # _____ Medicare # _____

Special medical needs: Please check any that apply

____ Receives care from licensed nurse on a daily basis for: ____ Will your nurse or PCA be attending camp? ____

____ Diabetes: Insulin Dependent ____ Controlled by diet ____ Blood sugar testing required ____

Gastrostomy ____ Colostomy / Ileostomy ____ Catheter ____ Orthopedic Appliances ____ Nebulizer ____ Asthma ____ Seizures ____

You may be sent a questionnaire requesting more information which must be completed/returned to our office 2 weeks prior to check-in.

Allergies: List ALL types, food, drug, etc.: _____

MEDICATIONS: All medications received for a Friendship Ventures service **must be in their ORIGINAL CONTAINERS, properly labeled by a PHARMACIST** as to person's name, medication, dosage and times of administration.

Non- prescription (Over-the-counter) items must have a WRITTEN ORDER BY A DOCTOR.

Friendship Ventures' Medical Committee encourages that any extra items (such as vitamins) be placed ON HOLD during participation in this service.

| Medication: | Reason for use: | mg. | # tabs | Frequency | 8 am | 12:30 pm | 5:30 pm | 9 pm | Special Instructions: before, with or in food/crushed |
|-------------|-----------------|-----|--------|-----------|------|----------|---------|------|---|
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| for: | | | | | | | | | |
| for: | | | | | | | | | *additional space on back side |

Please check all that apply: swallows meds whole ____ crush meds ____ uses oral syringe (please send) ____ uses medicine spoon (please send) ____

Topical medications and treatments: (Please state specific instructions for use of drops, ointments, dressings, treatments, etc.)

Bowel Program (check all that apply): MOM 2nd day without BM ____ Suppository if no results from MOM ____

Fleets enema if no results from suppository ____ Bowel Program Not Applicable ____

Check if individual is subject to the following:

- ____ sunburn
- ____ frequent colds
- ____ dizziness/fainting spells
- ____ constipation
- ____ menstrual problems
- ____ frostbite
- ____ bronchitis
- ____ ear infection
- ____ diarrhea
- ____ vaginal infections
- ____ sore throat
- ____ pneumonia
- ____ sinus infection
- ____ nausea/vomiting
- ____ urinary infections
- ____ skin rash
- ____ hernia
- ____ must not get water in ears
- ____ stay out of water
- ____ other: _____

Please comment on the above checked items regarding treatment routine: _____

Describe the mental, emotional or psychological needs that will impact participant's interaction or participation: _____

This Health History is correct so far as I know and the person herein described has permission to engage in all activities except as noted.

Exceptions: _____

PERSONS CHECKING- IN PARTICIPANTS must be able to answer questions regarding participants:

- A. Medication and health details.
- B. Special diet details.
- C. Special appliances or other medical needs.

If there is a change in the participant's health or medications, or if they have had surgery within 3 weeks prior to arrival, please call the Director of Health Care at (952) 852-0105 to determine if we are able to accept this participant.

Form completed by: _____ **Date:** ____ / ____ / ____

