Rainbow Homes Travel Club Medical and Health History Form

2111 Adelpha Ave. Holt MI 48842
(517) 699-8454
rhclsprog@gmail.com

PERSONAL

Name: _____ DOB: _____
First Middle Last Preferred

Seizures: Yes No Gender: Male Female Religion: _____

Allergies (Medications, Latex, Bandaids, Food, Bee Stings, & Environmental Etc): _____

_____

Reactions: _____

_____

Carry an Epi Pen? Yes No Know how to use an Epi Pen? Yes No

Group Home Name/Support Staff: _____ Group Home #: _____

Personal Address: _____

Phone #: _____ Cell Phone #: _____

Social Security #: _____ State ID #: _____

SUPPORTS

CMH #: _____ Case Manager: _____ Phone #: _____

Guardian: _____ Relation: _____ Phone #: _____

Payee/Conservator: _____ Relation: _____ Phone #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

INSURANCE INFORMATION

Medicaid #: _____

Medicare #: _____ Part A: _____ Part B: _____

Other Insurance Co.:_____ Policy #_____Group #_____

Prescription/ Drug Plan #: _____ RX Group: _____ RXBIN: _____

RXPCN: _____ Issuer: _____

Other Insurance Information: _____

MEDICAL

Medical Diagnosis: _____

Mental Health Diagnosis: _____

Primary Doctor: _____ Doctor Phone #: _____

Height: _____ Weight: _____

ON-GOING CARE, (Please check all that apply)

___ Hepatitis A, B, C ___ Sleep Apnea ___ Diabetes ___ Emotional Issues

___ Bowel Issues ___ Heart Conditions ___ Acid Reflux ___ Prostrate Issues

___ HIV / AIDS ___ Urinary Issues ___ Cancer ___ Arthritis

___ Asthma ___ Chronic Ear Issues ___ Skin Issues ___STD's

Other Please Explain: _____

ASSISTIVE DEVICES (Please check all that apply)

___ Hearing Aids ___ Glasses/Contacts ___ Dentures ___ Brace/AFO

___Cane ___ Walker ___ Comp. Stockings ___ Shower Chair

___C-Pap or Bi-Pap ___ Sleep propped up

___ Under Garment Protection ___ Day ___Night ___ Both

___ Wheel Chair ___ All day ___ Long distance only Bringing own Wheel Chair? Yes No

If bringing own wheelchair please note if collapsible _____

Other Please Explain: _____

_____

DIETARY NEEDS

___Diabetic Diet ___Low Salt ___Low Fat

___Reduced Calorie Diet ___Needs Food Cut Up

Other Dietary Concerns _____

ASSISTANCE/REMINDERS *(Please fill in R for Reminders and A for Assistance)*

___ Showering ___ Brushing Teeth ___Shaving

___ Not Over Eating ___ Healthy Choices ___ Wandering from Group

___ Going to Bed / wake up ___ Use Restroom ___ Keeping track of belongings

___ Changing to Clean Clothing ___ Choosing Appropriate Clothing ___ Taking Medication (explain)

___ Other assistance needed, please describe: _____

OTHER

___ Drinks Alcohol ___ Frequent or Problem Drinker ___Smoke ___ Chews Tobacco

___ Use of Recreational drugs

_____

PREFERRED WAKE UP METHOD

___ Set Alarm ___Call Phone or Room ___ Name Spoken ___Gentle Touch

MONEY (How much money can Traveler have on their person at a time?)

___ None
___ $5.00 ___$10.00 ___$15.00 ___ $25.00 ___ more than $25.00 ___ Uses a Debit or Credit Card

PERFERRED OVER THE COUNTER MEDICATION (OTC) IF NEEDED

Pain or Head Ache ___Tylenol/Acetaminophen ___Motrin/Ibuprofen ___ Naproxen/ Aleve
Other:_____

Stomach Ache ___ Tums ___ Pepto Bismo or Other: _____

Anti Diarrheal ___ Imodium or Other: _____

Motion Sickness ___ Dramamine or Other: _____

Cough / Cold ___ Day/ Nyquil ___ Coricidin (High Blood Pressure) or Other:_____

Menstrual Issues ___ Midol ___ Ibuprophen/ Motrin Or Other: _____

Please List any other OTC that may be given: _____

_____

MEDICATIONS (Attach Additional Medication list)

Med Name: _____ Dose: _____ Often: _____
Reason: _____

Med Name: _____ Dose: _____ Often: _____
Reason: _____

Med Name: _____ Dose: _____ Often: _____
Reason: _____

Med Name: _____ Dose: _____ Often: _____
Reason: _____

Med Name: _____ Dose: _____ Often: _____
Reason: _____

Med Name: _____ Dose: _____ Often: _____
Reason: _____

SURGERIES/PAST HOSPITALIZATIONS (Include any Psychiatric Hospitalizations)

When: _____ Reason: _____
Where: _____

When: _____ Reason: _____
Where: _____

When: _____ Reason: _____
Where: _____

When: _____ Reason: _____
Where: _____

VACCINES

TB Date: _____ (+ or -) Tetanus Vaccine Date: _____

Flu Vaccine: Date: _____ Pneumonia Vaccine Date: _____

Please also include a copy of Traveler's State ID as well as any Insurance Cards or information.

Please sign this below stating that you have filled this form out to the best of your medical knowledge.

_____

Signature of Traveler/Guardian Date

Emergency Release

This is authorization for Rainbow Homes or its Agents to seek emergency medical treatment in case of serious accident or illness, or to make whatever arrangements necessary to meet immediate health needs. I understand that Rainbow Homes Bears No Financial responsibility for the emergency services secured on my ward behalf.

By signing this form, I also understand that I am authorizing the release of medical information concerning me/my ward. This may include information regarding AIDS, AIDS related complex (ARC), Human Immunodeficiency Virus (HIV), or other communicable diseases for the purpose of providing appropriate care or services for me/ my ward.

I understand that this information is to be used for the stated purposes only and is valid for only two years. I understand that I can withdraw my permission at any time.

Signature of Traveler/Guardian Date

The **Photo release** is optional. The facilitators and volunteers of Rainbow Homes take pictures during Travel Club trips and activities to record events, provide documentation for grants and provide pictures for education. The Rainbow Homes facilitators will do their best to notify you of any picture(s) or videos to be used by any local media/ news station when you have agreed to picture/ video. At no time will the Rainbow Homes facilitators or volunteers take pictures that appear inappropriate.

Signature of Traveler/Guardian Date

For Rainbow Homes Office use only.

Received Date: By:

Health Form Expires (2 years from received year)

Dropbox/Forms 1/Trips/Trip Forms/Health From 2016
Revised 2/18/16