



Rainbow Homes Travel Club Medical and Health History Form

2111 Adelpha Ave. Holt MI 48842

(517) 699-8454

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PERSONAL

Name: _____ DOB: _____

Seizures: Yes No Gender: Male Female Religion: _____

Allergies (Medications, Latex, Band-aids, 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)

- | | | | |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emotional Issues |
| <input type="checkbox"/> Bowel Issues | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Prostrate Issues |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Urinary Issues | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Ear Issues | <input type="checkbox"/> Skin Issues | <input type="checkbox"/> STD's |

Other Please Explain: _____

ASSISTIVE DEVICES (Please check all that apply)

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Dentures | <input type="checkbox"/> Brace/AFO |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Walker | <input type="checkbox"/> Comp. Stockings | <input type="checkbox"/> Shower Chair |
| <input type="checkbox"/> C-Pap or Bi-Pap | <input type="checkbox"/> Sleep propped up | | |
| <input type="checkbox"/> Under Garment Protection | <input type="checkbox"/> Day | <input type="checkbox"/> Night | <input type="checkbox"/> 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

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Diabetic Diet | <input type="checkbox"/> Low Salt | <input type="checkbox"/> Low Fat |
| <input type="checkbox"/> Reduced Calorie Diet | <input type="checkbox"/> 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

PREFERRED 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 Form 2016
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