

**WINDWARD SENIORS DAY CARE
PHYSICIAN REPORT – ANNUAL RENEWAL**

Hope Center 261-4947
77 N. Kainalu Drive
Kailua, HI 96734

Leedham Center 261-5027
1276 Kailua Road
Kailua, HI 96734

DATE _____

_____ is applying as a participant in the Windward Senior Day Care Adult Day Care Program. The Centers are required by the State of Hawaii to have on file and annual physician's report and an annual T.B Clearance. Thank you for completing the following with information regarding the applicant's health status.

Sincerely,

Kelika Ishol
Director

1. 1. Medical Conditions:

wt. _____ bp _____ code status _____

2. 2. Activity Limitations: _____

3. 3. Diet: _____

4. 4. Known Allergies: _____

5. 5. Medications:

a. _____ b. _____
c. _____ d. _____

6. 6. May aspirin / Tylenol be given? _____

7. 7. TB results date:

PPD reading: _____ Chest Xray _____

Physician name: _____
Print signature date

I hereby authorize my physician to release any medical information to WSDC Hope/Leedham Centers.

Patient or patient rep signature.