



CLEVELAND VOCATIONAL INDUSTRIES, INC.
GENERAL MEDICAL EVALUATION

(Please complete and return even if the information has not changed)

Name: Birth date:

Sex: Age: Social security:

Address:

Home phone number: Other number:

Primary contact:

Address:

Home phone: Work phone:

Emergency contact: Relationship:

Home phone: Work phone:

HEALTH HISTORY: please indicate if you have been treated for any of the following conditions:

FREQUENT INFECTIONS: HEART DEFECT/DISEASE:
SEIZURES: DIABETES:
BLEEDING DISORDER: HEPATITIS:
CHICKEN POX: MEASLES:
GERMAN MEASLES: MUMPS:
ASTHMA: TUBERCULOSIS:

ALLERGIES:

HAY FEVER: POISON IVY/OAK:
INSECT STINGS: PENICILLIN:

OTHER ALLERGIES:

Operations or serious injurious with dates:

Chronic or reoccurring illness not mentioned above:

Date of last tetanus shot:

Activities to be discouraged: _____

Restrictions/Limitations: _____

Special diet or assistance required with meals: _____

Name of family doctor: _____ Phone #: _____

Name of family dentist: _____ Phone #: _____

Private Insurance Carrier: _____

Policy #: _____

Medicaid Number: _____ Medicare Number: _____

List any medications you are currently taking:

Medication	Amount	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other special needs: _____

Reminder: if at any time you need CVII staff to administer medication, we will need a med. Order from the doctor. Also, all medication must be in a childproof bottle that is labeled by the pharmacist with the person's name, the name of the medication, and the number of pills. The number pills on the label must match the number of pills in the bottle or we will not accept them.

Signature of person completing this form: _____

Relationship to client: _____

Date: _____

Please complete and return this form as soon as possible.