Rehabilitation Society of Southwestern Alberta
and
Joblinks Employment Centre
Medical Profile Form

Name: _____ Date of Birth (y/m/d): _____

Address: _____ Sex: _____

_____ Alberta Health Care#: _____

Residential Contact: _____ Phone Number: _____

Guardian: _____ Phone Number: _____

Doctor: _____ Phone Number: _____

Clinic: _____

1. Does the individual have any medical conditions staff should be aware of (ex. Epilepsy, heart murmur, high blood pressure)?

_____

_____

2. Date of individual's last medical: _____

3. Does the individual wear/require any type of aids (walkers, canes, hearing aids, glasses, dentures, braces etc)? Please specify:

_____

_____

4. Are there any activities the individual should not participate in, due to medical or physical concerns?

_____

_____

5. Does the individual have any allergies? Please specify:

_____

_____

6. Does the individual have any physical restrictions? (y/n)

a) Lifting _____ If yes, how much? _____

b) Standing _____ If yes, how much? _____

c) Sitting _____ If yes, how much? _____

d) Other _____

7. Is there any other information staff need to be aware of in order to complete risk assessments and support plans in order to provide a healthy, safe, and supportive environment?

_____

_____

8. a) Is the individual on any medication? _____ Regular _____ PRN _____ Other

b) Does the individual require staff to administer medication during program hours? _____ *

* If yes, a Request for Medication Administration sheet must be completed

* If no, document all medications that are self-administered or taken at home.

Specify Regular Medications: (daily, weekly, monthly)

Please provide current pharmacy copy of all medications.

Medication	Dosage	Time	Why Prescribed

Please list any possible side effects of the above medications:

_____

_____

_____

Specific P.R.N. medications: (Prescribed by doctor and given when required, including pain relievers)

Medication	Dosage/Times	Why Prescribed	Criteria	Possible Side Effects

Print name of person completing report: _____ _____

Signature of person completing report: _____

Date: _____

Guardians Signature: _____

Date: _____

Other: Please list non-prescription and herbal medications taken regularly

Medication	Dosage/Times	Why	Possible Side Effects

****Individuals/Guardians/Residential Staff have informed pharmacist of all non-prescription and herbal remedies the individual is taking.****