HEALTH SCREENING AND CLEARANCE
TO PARTICIPATE IN TREATMENT SERVICES

The following documents are to be filled out by a Primary Care Provider.

1. Medical Information/medical clearance including TB Screening Results
2. Approval for self-administered Over-the-Counter Medications PRN

If you have not had a PPD (TB Screening) within the past 12 months, please schedule an appointment with your health Care provider and have the result included with or on your medical clearance form.

Dena A Coy is not requiring COVID-19 vaccination. The vaccine is, however encouraged for anyone planning to enter a group living setting.

*Additional medical information or screenings may be required.

Name_____
DOB_____
MRN#_____

Southcentral Foundation's Behavioral Services Division
Dena A Coy Program

Southcentral Foundation

The following medical information form (or its equivalent) must be completed by your health care provider in order to participate in the Southcentral Foundation Program.

If there are any questions or concerns, please contact: _____

Name: _____ Date of Birth: _____

Does this patient have any detoxification needs prior to entering treatment?: ☐ **No** ☐ **Yes**

Are there any physical impairments/limitations: _____

Are there any communicable diseases: _____

Date of TB screening and results: _____

COVID-19 Vaccine complete? ☐ **No** ☐ **Yes** Type/Date(s): _____

Is the patient pregnant? ☐ **No** ☐ **Yes** EDC?: _____

PHYSICAL EXAMINATION

SYSTEM	NML	ABNML
HEENT		
Neck/Thyroid		
Heart		
Lungs		

SYSTEM	NML	ABNML
Abdomen		
Extremities		
Neurological		
Genital		

List known food, medication, or environmental allergies:

_____

☐ This patient has been medically evaluated and cleared to participate in counseling, education, and/or activity groups for 5-6 hours a day.

☐ This patient has been medically evaluated and cleared to live in group care.

☐ This patient is medically cleared to participate in moderate aerobic and strength training exercises.

Name_____
DOB_____
MRN#_____

List all current prescription Medications:

Medication	Dose	Frequency & Route	Indication

If the patient is prescribed addictive or narcotic medications, are there non-narcotic alternatives? ☐ **No** ☐ **Yes**

If yes, please list_____

☐ I have evaluated _____ and believe that this customer-owner is capable and competent to self-administer their own medications, as prescribed.

_____ _____ _____
Provider Signature & Credentials **Date** **Phone**

_____
Provider Name Printed

For Customer to Complete

I, _____, am able to self-administer the medications prescribed to me, including if needed, the physician approved over-the-counter medications above. I will be responsible to ask the staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting the medication I take at the time I take it on the "Self-Administration of Documentation form."

_____ _____
Customer Signature Date

BSD Health Care Provider Approval for Adult OTC PRN Medication(s) Order Form

Provider: *Mark* Yes or No for the following medication(s) to indicate your approval status
☐YES ☐No **Acetaminophen** (Tylenol) 1000 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER/MENSTRUAL CRAMPS ☐YES ☐No **Acetaminophen** (Tylenol) 650 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER/MENSTRUAL CRAMPS Maximum 2000mg/24 hours ☐ Maximum 4000 mg/24 hours ☐
☐YES ☐No **Ibuprofen** (Advil, Motrin) 400 mg by mouth every 4 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐No **Naproxen** (Aleve) 200 mg (220 mg tab) by mouth every 8 hours as needed for PAIN/MUSCLEACHE/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐No **Calcium Carbonate** (Tums) 1000 mg by mouth every 4 hours as needed for HEARTBURN
☐YES ☐No **Bismuth Subsalicylate** (Pepto-Bismol) 30 ml or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
☐YES ☐No **Docusate Sodium** (Colace) 100 mg by mouth two times daily as needed for CONSTIPATION.
☐YES ☐No **Anti-gas tablets** (Beano) 2 tablets by mouth before meals as needed for FLATULENCE/GAS
☐YES ☐No **Lactaid** 1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
☐YES ☐No **Multivitamin** take 1 tablet (or 2 gummy vits) by mouth daily as needed for NUTRITIONAL SUPPLEMENT
☐YES ☐No **Loratadine** (Claritin) 10 mg by mouth daily as needed for SEASONAL ALLERGIES
☐YES ☐No **Phenylephrine Hydrochloride** (Sudafed PE) 10 mg by mouth once daily as needed for SEASONAL ALLERGIES
☐YES ☐No **Oxymetazoline 0.05% solution nasal spray** (Afrin) 2 sprays each nostril 2 times a day as needed for NASAL CONGESTION
☐YES ☐No **Guaifenesin** (Robitussin) 10 ml by mouth every 4 hours as needed for COUGH
☐YES ☐No **Cough Suppressant** (Halls, cough drop) 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
☐YES ☐No **Diphenhydramine hydrochloride** (Benadryl) 25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION. Consult health care provider if symptoms worsen or persist
☐YES ☐No **Diphenhydramine hydrochloride** (Benadryl) 50 mg by mouth at bedtime as needed for INSOMNIA. If used for 10 consecutive nights consult health care provider
☐YES ☐No **Nicotine lozenges** 2 mg lozenge by mouth every 2 hours as needed for 6 weeks for TOBACCO CRAVINGS ☐YES ☐No **Nicotine patches** as determined by a Tobacco Treatment Specialist or the Alaska Quit Line
☐YES ☐No **Benzocaine local anesthetics** (Orajel) apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
☐YES ☐No **Topical antibiotic ointment** (Neosporin) apply thin layer to affected skin area 2 times daily as needed for MINOR SKIN ABRASION/CUT/SCRAPES
☐YES ☐No **Hydrocortisone acetate 1% cream** apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
☐YES ☐No **Clotrimazole 1%** (Lotrimin) apply thin layer to affected skin area 2 times daily as needed for ATHLETE'S FOOT/JOCK ITCH/RINGWORM
ALLERGIES:

I, _____, am able to self-administer the medications prescribed to me, including if needed, the physician approved over-the-counter medications above. I will be responsible to ask the staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting the medication I take at the time I take it on the "Self-Administration of Medications Documentation form."

_____/_____ _____
Customer-owner Signature & Initials Date

I have evaluated _____ and believe that this customer-owner is capable and competent to self-administer their own medications, as prescribed. Please keep the above approved over-the-counter medications on file should it become indicated for the customer-owner to use for treatment of minor conditions while in the program. These orders are authorized for one year from the date of my signature, or until there has been a change in the customer-owner's condition that would affect their ability to self-administer their medications.

_____ _____
Provider Signature & credentials Date

_____ _____ _____ _____
Customer-owner Name Date of Birth Phone number Fax number

MRN#_____ Revised April 2020