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.