A Division of Senior Services
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Gary W. Marchese Jr.,
Director
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2024 Yearly Medical Update

Dear Doctor:_____ Date_____

Your patient,_____

of _____
Street Town State Zip

is attending **the Passaic County Adult Day Care Program.** Our client's medical information must be updated yearly. To meet the needs of your patient, your cooperation in supplying the following information is of utmost importance.

PLEASE PRINT OR TYPE

1. Physical problems:
2. Mental/ Emotional problems:
3. Weight and Blood Pressure:
4. Diagnosis:
5. Activity restrictions:
6. Allergies (includes aspirin and anti-acid):
7. Diet requirements:
8. When was patient last seen?
9. What is the age of patient?
10. Medication and/or treatments:

Physician's Statement:

I do / do not recommend that_____ attend the
Name of patient
Passaic County Adult Day Care Program.

_____
Signature of Physician

_____ _____
Address Telephone Number

_____ _____
Fax Number