



MEDICAL INFORMATION FORM

Client's name: _____ DOB: _____

Parent's name: _____

Address: _____

Home phone #: _____ Work phone #: _____

Primary insurance carrier: _____

Billing address: _____

Name of subscriber: _____

ID #: _____ Group #: _____

Dates of coverage: _____

Harbor Shelter may allow my child to take Tylenol, Robitussin or other non-prescription medications: Yes: _____ No: _____

My child is currently on prescription medication(s): Yes: _____ No: _____

I understand my child's diagnosis, the severity of symptoms, expected benefits, possible side effects and other treatment options: Yes: _____ No: _____

Harbor Shelter has my consent to continue my child on the current prescription medication(s): Yes: _____ No: _____

I realize that I have the right to refuse consent: Yes: _____ No: _____

Food or drug allergies: _____

Health concerns: _____

I understand that in case of an emergency, Harbor Shelter will arrange for medical services for my child. I also understand that they will attempt to contact me as soon as possible.

Parent's signature: _____ Date: _____