

<b>NAME</b>			
Address, Home Phone, Cell Phone, Email			
DOB	SS#	Allergy	DNR SIGNED: N/ Y – ADD DATE
<b>Learns best by:</b>			
<b>Supports Needed:</b>			
<b>Legal Decision Maker: __ Self</b>		<b>Guardianship: __ Limited __ Full</b>	
NAME:		PHONE:	
ADDRESS:			
<b>Legal Health Surrogate:</b>			
NAME:		PHONE:	

PRIMARY DIAGNOSIS/ICD-9 CODES	AGE: XX	HEIGHT X'X" (XX inches)	WEIGHT XX lbs
1. 2. 3. 4. 5.			

M E D I C A L	
<b>DOCTORS</b>	<b>HOSPITAL</b>
<b>MEDICINES</b> Rx <u>    </u> DAILY  Rx <u>    </u> MONTHLY  Rx <u>    </u> PRN	<b>IMMUNIZATIONS</b>
ADD NAME OF INSURANCE COMPANY  <i>Primary Subscriber:</i> ADD NAME ADD Plan Code # ADD Subscriber # Customer service: ADD PHONE #	ADD NAME OF INSURANCE COMPANY  <i>Subscriber:</i> ADD NAME ADD Plan Code # ADD Subscriber # Customer service: ADD PHONE #

<b>Health Care/ Case Manager</b>	ADD NAME	ADD PHONE #	ext. xx
<b>Health Vendor</b>	ADD COMPANY NAME/CONTACT	ADD PHONE #	ADD acc't. #
<b>Home Nursing Agency</b>	ADD COMPANY NAME/CONTACT	ADD PHONE #	ADD acc't. #
<b>Pharmacy</b>	ADD COMPANY NAME	ADD PHONE #	ADD RX #s
<b>Dentist</b>	ADD NAME	ADD PHONE #	