TRI-CITY HELPING HANDS SERVICES DAY CENTER INTAKE

CLIENT NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

CITY: _____ ZIP: _____

MEDICAID: _____

EMERGENCY INFORMATION

1ST CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ ZIP: _____

HOME NUMBER: _____ CELL NUMBER: _____

2ND CONTACE: _____ RELATIONSHIP: _____

ADDRESS: _____ ZIP: _____

HOME NUMBER: _____ CELL NUMBER: _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER: _____

HOSPITAL CHOICE: _____

I grant permission to Tri-City Helping Hands Services to obtain emergency medical treatment for client if deemed necessary by the staff in charge.

Client Signature: _____ Date: _____

Guardian/Parent: _____ Date: _____