

IRONWOOD RESIDENT PROFILE SHEET

Child's Name: _____ Age: _____ Gender: _____ DOB: _____
Address: _____ Race: _____
City, State, Zip: _____ Birthplace: _____
Child Lives With: _____
Religious Preference and/or Practices: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____
Pant Size: W _____" x L _____" Shirt Size: XS S M L XL XXL Shoe Size: _____
Social Security Number _____ Estimated date of admission _____

Medical Alerts

Is your child currently prescribed medications? Yes ___ No ___ If yes, what medications are they prescribed and what is the dosage? _____

Prescribing Physician's Name: _____ Phone _____
Address: _____ Fax: _____

Does your child have any medical issues that the Ironwood staff should be aware of? Please include allergies, necessity of an epinephrine pen, diabetes, etc. _____

Please attach a copy of all current health/dental/prescription insurance cards, both front and back.

PARENT CONTACT INFORMATION

Father's Name: _____ Occupation: _____
Address: _____ Education: _____
City/State/Zip: _____ Age: _____
Phone: Home _____ Work _____ Cell _____
Other Phone _____ Fax _____ E-mail _____

Mother's Name: _____ Occupation: _____
Address: _____ Education: _____
City/State/Zip: _____ Age: _____
Phone: Home _____ Work _____ Cell _____
Other Phone _____ Fax _____ E-mail _____

Stepfather's Name: _____ Occupation: _____
Address: _____ Education: _____
City/State/Zip: _____ Age: _____
Phone: Home _____ Work _____ Cell _____
Other Phone _____ Fax _____ E-mail _____

Stepmother's Name: _____ Occupation: _____
Address: _____ Education: _____
City/State/Zip: _____ Age: _____
Phone: Home _____ Work _____ Cell _____
Other Phone _____ Fax _____ E-mail _____

IN CASE OF AN EMERGENCY NOTIFY: (when parents are not available)

Name: _____ Relationship to Applicant _____
Address: _____
City/State/Zip: _____
Phone: Home _____ Work _____ Cell _____
Other Phone _____ Fax _____ E-mail _____

My child has permission to communicate with the following people during his/her Ironwood stay:

Name	Address	Tel No.	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RESPONSIBLE BILLING PARTY

Resident's Name _____
Legal Guardian's Name & relationship to resident _____
Legal Guardian's address _____
City, State, Zip _____
Responsible Billing Party (if different from above) including name, address, telephone number and other contact information _____

Release of Confidential Information

I, _____, for (applicant) _____, authorize
(name) _____ at (address) _____
_____ to furnish to Ironwood, LLC, 67 Captain Cushman Rd., Morrill, ME 04592,
the following records/documentation: Medical Records, Immunization Records, School Records,
Psychiatric Reports, Psychological Reports, Progress Notes, Discharge Summaries, Disciplinary Reports,
other (please list) _____. I
understand that I may review material to be released. I (do/do not) waive this right. I release the above-
named provider from all claims pertaining to disclosure of this information. I understand that I have the
right to revoke permission for release at any time in writing, if such release has not yet been acted upon.

Signature of Parent/Legal Guardian	Date	Signature of Witness	Date
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