Saint Joseph Living Center
14 Club Road
Windham, CT 06280
Phone # 456-1107 or Fax # 456-1695

- Medical information must
- Be submitted as part oft
- Completed application

Date: _____

MEDICAL PROFILE

Name: _____ Sex: _____
Address: _____ Phone: _____
_____ SS#: _____

Diagnosis:

_____
_____
_____
_____

Operations:

_____
_____
_____
_____

Diet:

_____

Allergies:

_____

Treatments (Specify equipment, ie respiratory, etc.)

_____
_____
_____

Medications-dose-frequency:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Additional information:

_____
_____
_____

_____**MD** _____**MD**
Name (Please Print or Type) **MD Signature**

MD Address:_____
_____