Stevens County Developmental Achievement Center
203 Green River Road
P.O. Box 25
Morris, Minnesota 56267

Admission Date: _____
FOR OFFICE USE ONLY

ADMISSION FORM (Social History)

Client Name: _____ Birth date: _____
Last First Middle

Address:_____
Street City State Zip Code

Place of Birth: _____ Telephone #:_____
County State

Residential supports (i.e. natural family, ICF/MR, foster care, etc.): _____

Social Security #:_ _____Gender: _____ Marital Status: _____

Schools attended (please list dates, diplomas, program type): _____

_____

_____

_____

_____

_____

(additional information may be written on back)

Programs attended (please list dates, program type, and purpose of attendance for any other day programs, clinics, institutions, etc.): _____

_____

_____

_____

_____

_____

(additional information may be written on back)

Client Name: _____
Last First

ADMISSION FORM (Emergency Information)

Legal Status (i.e. legally competent adult, guardian, conservator): _____
If a guardian or conservator has been assigned please fill out the information below;

Name: _____ Telephone #: _____
Last First Middle

Address:_____
Street City State Zip Code
(additional information may be written on back)

Emergency contact person(s):
Please supply information for at least one emergency contact person below;

Name: _____ Telephone #: _____
Last First Middle

Address:_____
Street City State Zip Code

Name: _____ Telephone #:_____
Last First Middle

Address:_____
Street City State Zip Code
(additional information may be written on back)

County of Case Management: _____
Please supply information regarding the case manager below;

Name: _____ Telephone: _____
Last First Middle

Address:_____
Street City State Zip Code

Religious contact (if any): _____

MN Identification Card #: _____

Insurance information (carrier and policy #): _____

Client Name: _____
Last First

ADMISSION FORM (Emergency Information continued)

Primary physician name: _____

Clinic Name: _____ Telephone #: _____

Address: _____
Street City State Zip Code

Alternative physician name: _____

Clinic Name: _____ Telephone #: _____

Address: _____
Street City State Zip Code

Hospital of Preference: _____

Contact Name: _____ Telephone #: _____

Address: _____
Street City State Zip Code

Dentist name: _____

Clinic Name: _____ Telephone #: _____

Address: _____
Street City State Zip Code

Other Medical Contacts:

Care giver Name: _____ Specialty: _____

Clinic Name: _____ Telephone #: _____

Address: _____
Street City State Zip Code

(additional information may be written on back)

Client Name: _____
Last First

ADMISSION FORM (Emergency Information continued)

Diagnosis: _____

Prosthetics (if any): _____

Dietary needs or food related allergies/sensitivity: _____

_____

Medication allergies: _____

Other allergies: _____

Current Prescribed Medications:

Medication / Dose / Frequency / Time / Route

1) _____
2) _____
3) _____
4) _____
5 _____
6) _____

Current Medical Treatments:

Treatment / Frequency / Time

1) _____
2) _____
3) _____
4) _____
5) _____

Other Concerns / Comments: _____

_____

_____

Client Name: _____
Last First

ADMISSION FORM (Family History)

* This information is not required for admission but it does help us meet the needs of our clients. Please include the information which you wish to disclose. Thanks!

Father:

Name: _____ Birth date: _____
Last First Middle

Address:_____
Street City State Zip Code

Occupation: _____ Telephone #: _____

Mother:

Name: _____ Birth date: _____
Last First Middle

Address:_____
Street City State Zip Code

Occupation: _____ Telephone #: _____

Siblings:

Name	Address	Birthdate	Gender
♦			
♦			
♦			
♦			
♦			
♦			

(additional information may be written on back)