Med-East Medical Walk-In Center

A Windham Hospital Partner

1703 West Main Street, Willimantic, CT 06226
Telephone (860) 456-1252 • Fax (860) 456-2278

200 Merrow Road, Tolland, CT 06084
Telephone (860) 871-5452 • Fax (860) 871-5712

Email: medeast@wcmh.org

Full name of child: ____

Home address: ____

____

Current or mailing address if different: ______________________________

____

Home telephone: ____________________________ **Date of birth:** ____________

Medication allergies: __________________________ **Physician:** ______________

Current medications: ____

Chronic medical problems: ____

Name of parent(s) or legal guardian(s): ______________________________

Telephone number where parent may be reached:____________________________

Health insurance information: ______________________________________

____

Insurance ID number: ____

(Optional: I give ____________________________ permission to accompany the above listed child to the physician's office/hospital.)

I, ____________________________ give my written permission for such treatment and
PARENT OR LEGAL GUARDIAN
medications as may be deemed necessary or advisable in the treatment and diagnosis of the above listed child's condition. I acknowledge that no guarantees have been made to me as to the results of such treatment.

Signature: ____ **Date:** ____________
PARENT OR LEGAL GUARDIAN

This form is valid for one year from date of signing.