pennsylvania
DEPARTMENT OF HEALTH

Safe Harbor Physician Form

To be Completed by the Parent/Legal Guardian/Caregiver/Spouse

Minor's name:		Date of birth:
Minor's address:		
Minor's city:	Minor's state:	Minor's zip:
Parent/legal guardian/caregiver/spouse's name:		
Parent/legal guardian/caregiver/spouse's phone number:		
Parent/legal guardian/caregiver/spouse's date of birth:		

To be Completed by a Pennsylvania-Licensed Physician

Please check the minor's serious medical condition:

- ☐ Autism
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ HIV/AIDS
- ☐ Huntington's Disease
- ☐ Inflammatory Bowel Disease
- ☐ Intractable Seizures
- ☐ Multiple Sclerosis
- ☐ Neuropathies
- ☐ Parkinson's Disease
- ☐ Post-Traumatic Stress Disorder
- ☐ Sickle Cell Anemia
- ☐ Severe Chronic or Intractable Pain
- ☐ Spinal Cord with Intractable Spasticity

Physician name:			
Practice name:			
Practice address:	City:	State:	Zip:
Practice phone:	Pennsylvania license number:		
Physician signature:		Date:	

To be Completed by the Department of Health

Initials of reviewer:	Date of review:	Approval code:

This form will be finalized by the Pa. Department of Health and returned to the parent and physician.