LSCO LETHBRIDGE Senior Citizens ORGANIZATION

Adult Day Program Registration Form

Date:_____

Demographic Information

Name:_____
(First) (Last)

Address: _____
(Street) (City) (Postal Code)

Building Name: _____
(if applicable)

Phone:_____ Email address:_____

DOB: _____ AHC # _____

Health Information (ie. diagnosis, physical limitations, developmental challenges, safety concerns to be aware of)

_____

_____

_____

Rx list attached: ☐ yes ☐ no Receiving AHS Home Care Services: ☐ yes ☐ no

Name of Home Care Nurse: _____

Contact Numbers

1. Name: _____ Relationship: _____

   Phone: _____ Email address:_____

   Live local? ☐ yes ☐ no Key to your home? ☐ yes ☐ no

2. Name: _____ Relationship: _____

   Phone: _____ Email address:_____

   Live local? ☐ yes ☐ no Key to your home? ☐ yes ☐ no

Dietary Restrictions

_____

_____

Allergies (Rx or food): _____

Consent for Photo Release

Individual's Name: _____

I,_____ or legal guardian for the above named individual,

hereby authorize and grant permission to having photographs taken for in-house or individual use only.

I,_____ or legal guardian for the above named individual, do

not authorize or grant permission to having photograph releases.

Signature of Member or Guardian Date

_____ _____