



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): _____

Waiver

1. To the best of my knowledge, I am physically sound and have medical approval by my doctor to participate in **physical exercise activities** of the type normally engaged in a voluntary / nonprofit health and **fitness facility and physical activities** like those offered at LSCO.
2. I understand there is a risk of personal injury, death or loss of or damage to personal property by my participation in the programs offered at LSCO and that I fully assume all responsibilities and liability of risk from my participation.
3. Membership, programs and classes are non-transferable. LSCO memberships are non refundable.
4. I have carefully read and understand its contents. I have voluntarily signed of my own free will.

Signature of Member or Guardian

Date

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.

_____ or legal guardian for the above named individual, do

not authorize or grant permission to having photograph releases.

Signature of Member or Guardian

Date
