City of Columbiana
Senior Services
110 Mildred Street
Columbiana, AL 35051
205-669-3969

FOR OFFICE USE ONLY:
Date: _____ Approved: _____
◯ **Copy of ID on file**
◯ **Congregate Meal Program**
◯ **Activities Only**
◯ **Clastran Application on file**
◯ Copy of COVID VAX on File

SENIOR CENTER REGISTRATION FORM FY 2022

First Name: _____ MI: ____ Last Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ ◯ Female ◯ Male

Are You a Veteran? ◯ Yes ◯ No Military Branch: _____

Allergies: _____

Do you require an (A) **Epipen** Yes ☐ No ☐ (B) **Inhaler** Yes ☐ No ☐

Please list all medical conditions we should be aware of:

INDEPENDENCE QUESTIONARE:

Do you need assistance using the bathroom? ◯ Yes ◯ No Explain: _____
Do you need assistance walking or standing? ◯ Yes ◯ No Explain: _____
Do you need assistance eating? ◯ Yes ◯ No Explain: _____
Do you have a dementia or Alzheimer's diagnosis? ◯ Yes ◯ No Explain: _____

(If you answer yes to any of the above questions, your membership will need to be reviewed by the director. Answering yes does not exclude you from the senior center but we need to make sure you are independent enough to participate in programs without a caregiver.)

1. EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

Phone Number: _____ Alternate Phone Number: _____

2. EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

Phone Number: _____ Alternate Phone Number; _____

By signing below you affirm that the above information is true and correct and that you have read and will adhere to the policies of the Columbiana Senior Center. By signing below you give the Columbiana Senior Center and the City of Columbiana permission to use your photo for promotional and informational purposes. With your signature below you authorize, in the event of an emergency, the Columbiana Senior Center and its agents to obtain medical attention for you and you hereby give consent for the first available first responder to administer any necessary medical examinations or treatment.

_____ _____
Signature Date

CONFIDENTIAL