

NAPERVILLE SENIOR CENTER MEMBER INFORMATION

Member Name:	DOB:
Address:	Home Phone: Cell Phone:
City:	Zip:
SSN:	Email Address:
Long Term Insurance:	Other Entitlement (specify):
Living Arrangement: ☐ Alone ☐ Spouse ☐ Partner ☐ Adult Child ☐ Other (specify):	
Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Partner ☐ Divorced or Separated	
Race/Ethnicity: ☐ White, not Hispanic Origin ☐ Black, not Hispanic Origin ☐ Hispanic ☐ Asian, Pacific Islander ☐ American Indian ☐ Other (specify):	
Language Spoken: ☐ English ☐ Spanish ☐ Other (specify):	
Religion: ☐ Jewish ☐ Muslim ☐ Christian (specify): ☐ Other (specify):	
Level of Education: ☐ 0-6th grade ☐ 7-12th grade ☐ Diploma or GED ☐ some college ☐ college graduate	
Veteran Status ☐ No ☐ Yes (if YES, specify which branch):	
Former Occupation:	
Current Interests:	

Emergency Information:

(Please check box if this person is authorized to pick up the Member from Naperville Senior Center. On the back of this sheet, please list any other people who are authorized to pick up the Member)

☐ 1st Responsible Person:	Relationship:
Address:	Zip Code:
Home Phone:	Cell phone: Work Phone: ☐
Email:	
☐ 2nd Responsible Person:	Relationship:
Address:	Zip Code:
Home Phone: Cell phone: Work Phone:	
Email:	
Primary Care Physician	Phone Number:
Physician Address:	
HOSPITAL CHOICE: ☐ Edward ☐ Good Sams ☐ DMC ☐ OTHER (SPECIFY):	
BILLING SENT TO: ☐ Billing sent to Member ☐ 1st Responsible person ☐ 2nd Responsible Person ☐ Other (specify): Relationship:	
BILLING ADDRESS:	

Office Use Only: Date form reviewed: _____ Date service started: _____ Funding: _____ Days attending: _____
Transportation: _____ Safe Return Sent: _____ Date discharged: _____ Reviewed by: _____

Medical Information and Permissions

Member Name

Vaccination History

Type	Date	Type	Date
Flu		Pneumonia	
Shingles		TB Test	

List all medications taken by the above at home and at Naperville Senior Center, along with the exact dosage and the hour(s) of day the medication is taken.

PLEASE NOTE: In accordance with regulations, any medication dispensed by Naperville Senior Center nurses must be in properly labeled original containers. Labels MUST include: the Member's name; doctor's name; medication name; time and amount prescribed.

****NO MEDICATION WILL BE DISPENSED WITHOUT A PHYSICIAN'S ORDER AND PROPER LABELING****

A weekly or monthly supply should be sent to the site, to be refilled as needed.

Name Of Medication	Dosage (Example: 100 MG)	Time Of Day Taken (Example: 8 am & 8 PM)

PLEASE NOTE: DOCTOR ORDERS ARE NEEDED FOR Over-the-counter medications such as Tylenol!

I grant permission to the Naperville Senior Center nursing staff to dispense any needed and properly prescribed, labeled medication to:

Member Name	Date
Signed	Relationship

The state of Illinois requires written authorization for the dispensing of non-aspirin pain relievers (such as Tylenol) by nursing staff to Members.

I grant permission to dispense a non-aspirin pain reliever to the below named Member on an as needed basis to:

Member Name	Date
Signed	Relationship

EMERGENCY MEDICAL CARE

I grant permission to Naperville Senior Center to obtain emergency medical treatment for if deemed necessary by the staff in charge.

Member Signature: _____ Date: _____

Responsible Party: _____ Date: _____

ALLERGIES

Please list any food, medication or other allergies:

Please list any other medical information that would help us work better with the Member:

Waiver of Responsibility

I waive the Naperville Senior Center staff and assistants of all responsibility in case of accident, injury, illness or loss of property.

Signature of Member or
Responsible Representative

Date

Emergency Pick-Up

Naperville Senior Center has trained personnel, including a nurse(s), who strive to act in the best interest of the Members. Occasionally, a Member may become too ill to complete the day or may become too disruptive to remain in the center. If either occurs, the staff may need to call the family/caregiver to pick him/her up.

I agree to pick up _____ if the staff determines it necessary.

I will make alternate arrangements for emergency pick-up on days I might not be easily reached.

I further agree to inform Naperville Senior Center staff of any situations or occurrences, which may affect the Member's behavior while at the center.

Signature of Member or
Responsible Representative

Date

Media Release

Naperville Senior Center frequently updates Social Media (Facebook, Pinterest...) and often receives requests from the media to take pictures/videos of Members which may be posted on the Internet and distributed to the public. Please check below to allow your picture or that of your family member to be posted on the Internet and released to the public.

___ I APPROVE FOR MY PHOTO TO BE POSTED ON THE INTERNET AND RELEASED TO THE PUBLIC.

Signature of Member or
Responsible Representative

Date

Hours of Service Calendar Signature Verification Form

The *Hours of Service Calendar* documents the dates and hours of each Member's attendance at Naperville Senior Center. It is signed by the Member and a staff person on the last day of each month. If a Member is absent or otherwise unable to sign at that time, this form gives permission for a designated staff person to sign for him or her. In the event of the above named person's absence or inability to sign the *Hours of Service* calendar, I hereby grant permission for a Naperville Senior Center staff person to sign in his/her place.

Signature of Member or
Responsible Representative

Date

Signature of Naperville Senior Center Staff Person

Date

**PHYSICIAN'S HEALTH ASSESSMENT/MEDICAL INFORMATION AND
AUTHORIZATION FOR TREATMENT (Page 1 of 2)**

Member Name: _____ Date: _____

D.O.B.: _____ Age: _____ Sex: _____ Weight: _____
Height: _____ Heart Rate: _____ Blood Pressure: _____
TB test: _____ Flu Vaccine: _____ Pneumonia Vaccine: _____ Shingles Vaccine: _____

Contact physician if Blood pressure is above _____ or below _____ or N/A

Contact physician if BG level is above _____ or below _____ or N/A

Center RN may provide insulin injections as ordered: yes ____ no ____ or N/A ____

Diagnoses: _____

MEDICATIONS

Current Medical Exam

Cardiovascular:	Gastrointestinal:
Musculoskeletal:	Rectal:
Mouth/Throat:	Endocrine:
Respiratory:	Genitourinary:
Integumentary:	Eyes:
Nose:	Ears:

Allergies: _____

Other Pertinent Health History: _____

**PHYSICIAN'S HEALTH ASSESSMENT/MEDICAL INFORMATION AND
AUTHORIZATION FOR TREATMENT (Page 2 of 2)**

MAY WE HAVE STANDING ORDERS FOR: (Please Circle)

Tylenol 500 mg. 1 or 2 tabs po q 3-4 h PRN pain	Y	N
Mylanta 30 cc PO q4h PRN gastric discomfort	Y	N
Imodium AD 1 tab prn PRN diarrhea up to TID	Y	N
Benadryl PRN	Y	N
Antacids PRN	Y	N
Biofreeze PRN for pain management	Y	N

Does your patient require a special diet? ☐ No ☐ Yes (Please specify)

☐ **PATIENT MAY ADMINISTER THEIR OWN MEDICATION.**

☐ **NSC ADULT DAY HEALTH CARE REGISTERED NURSE (OR STAFF MEMBER) TO MANAGE THE ADMINISTRATION OF MEDICATIONS.**

Further orders (including any weight bearing restrictions): _____

I approve of my patient attending Naperville Senior Center: ☐ Yes ☐ No

Patient may participate in exercise program including light weights & walking: ☐ yes ☐ No

Physician Signature

Physician's full name

Physician Address: _____ Phone: _____

Member Name: _____ Date: _____

Naperville Senior Center fax #: 630-995-3917