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:_____ DNR status:_____
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 (Including MRSA, VRE, ESBL, C-Diff): _____

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

AUTHORIZED PERSONS FOR PICK UP

The following persons are authorized to pick up ______________________________ from Naperville Senior Center:

NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
NAME:		RELATIONSHIP
ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:

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Credit Card Information

First Name	Last Name
Street Address	City | State | Zip
Type of Card (circle) Visa | Discover | M C | Am Ex | Other	Card Number
Expiration Date:	Security code (3 digit): Am Ex (4 digit)
Signature:	