Dublin Community Senior Center Emergency Form

Your Name______________________________Phone #________________

Address__________________________________Birthdate______________

City________________________State______________Zip Code__________

In case of emergency, please contact:

Name_____________________Relationship___________Phone #____________

Name_____________________Relationship___________Phone #____________

Primary Physician_________________________ Phone #_________________

Please list your current medications: (If you have a list of medications, we can Xerox it)

Medication	Dosage	Condition treated

Please check any of the following health/physical conditions you have:

Diabetes____ Vision problems____ Hearing loss___ Seizures_____ Walker_____

Hypertension____ Cancer____ Lung condition_____ Speech impaired____ Cane____

Arthritis____ Heart condition____ Circulation problems___ Wheelchair____

List allergies (foods/medications/other)______________________________________

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Consent for the Release of Confidential Medical Information

I,_____________________________, authorize the Dublin Community Senior Center to disclose identifying information for the purpose of:

1. Notifying emergency contacts in the event of an emergency.
2. Providing medical information to emergency caregivers (if needed)

Member's signature:______________________________Date_______________

Guardian's Signature______________________________Date_______________