Serenity
Adult Day Care

Helping families care for their loved ones with compassion and dignity...one day at a time!

APPLICATION

NAME: _____ **DATE:**_____/_____/_____
ADDRESS:_____ **BIRTH DATE:**____ /_____/_____
CITY:_____ **ZIP CODE:**_____
HOME PHONE:_____/_____/_____ **CELL PHONE:**_____/_____/_____

(In case of an emergency we must have two contact people on file)

#1 EMERGENCY CONTACT PERSON:
NAME:_____ **RELATIONSHIP:**_____
HOME:____/_____/_____ **WORK:**_____/_____/_____ **CELL:**_____/_____/_____

#2 EMERGENCY CONTACT PERSON:
NAME:_____ **RELATIONSHIP:**_____
HOME:____/_____/_____ **WORK:**_____/_____/_____ **CELL:**_____/_____/_____

PHYSICIANS NAMES/ADDRESSES/PHONE #'S:
01)_____
02)_____
03)_____

DO YOU LIVE ALONE_____? IF NOT, PLEASE LIST THE NAMES OF ALL HOUSEHOLD MEMBERS
NAME:_____ **RELATIONSHIP:**_____
_____ _____
_____ _____
_____ _____

PLEASE LIST ALL DIETARY RESTRICTIONS/ALLERGIES:_____
PLEASE LIST ALL MEDICAL PROBLEMS BELOW. PLEASE BE DESCRIPTIVE!
_____
_____
_____

PLEASE LIST ALL DAILY MEDICATIONS AND DOSAGES. ARE YOU INSULIN DEPENDANT? _____
01)_____ **02)**_____ **03)**_____
04)_____ **05)**_____ **06)**_____
07)_____ **08)**_____ **09)**_____
WILL YOU NEED NURSE ASSISTANCE WITH YOUR MEDICATIONS? _____If yes, please explain…
_____
_____

(ALL INFORMATION PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE)
SIGNATURE OF PERSON COMPLETING APPLICATION:_____
RELATIONSHIP TO APPLICANT:_____ **DATE:**_____/_____/_____