Participant Form 2023

Name ____ Date of Birth ________________

Street Address ____

City _____________________________________ State ________ Zip ______________________

Email ____ Phone ______________________

Social Security # *(Last four digits)* ________

☐ Male ☐ Female

Do you currently live alone? ☐ Yes ☐ No

Do you make less than $17,500 per year? ☐ Yes ☐ No

Do you consider yourself to be handicapped? *(Includes use of cane, walker, legally blind, deaf, respiratory issues, heart issues, etc.)* ☐ Yes ☐ No

What is your ethnicity? ☐ White ☐ African-American ☐ Asian/Pacific Islander ☐ Native American/Alaskan

Other ______________________________ ☐ Prefer not to answer

Emergency Contacts *(Provide two)*

Name ____ Phone ______________________________

Relationship ____

Name ____ Phone ______________________________

Relationship ____

Physician ____________________________________ Phone ______________________________

List any chronic medical condition(s) and regular medication(s) you may require. ______________________

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Disclosure Statement

This **Sylvania Senior Center Participant Registration Form** is meant to assist the Ohio Department of Aging in monitoring the effectiveness of senior programs offered to Ohio citizens. Any participant information obtained from this form is confidential, and no personal identifying information will be released to any outside source without written consent or unless required under federal law.

As a participant of Sylvania Senior Center (Sylvania Community Services), I understand and agree Sylvania Community Services, Sylvania Senior Center, and their respective employees, officers, board members, and agents will not be held responsible or liable for any loss, damage, or related expense while rendering its services. Information you provide on this form may be provided to our funders upon request.

In a medical emergency, I agree medical provided on this form may be given to medical personnel.

Signature ____ Date ______________________

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