

PLEASE COMPLETE AND RETURN

ALOHA DAY CLUB – ADMISSION FORM

Participant Name _____ Nickname _____

Diagnosis _____

Precautions / Comments _____

PERSONAL INFORMATION:

Age _____ Birthday _____ Birthplace _____

Sex _____ Race _____ Religious Affiliation _____

Marital Status: M ___ S ___ D ___ Widow/er ___ How Long? _____ Spouse's Name _____

Name of Children _____

Place of Residence _____

People (#/Names) in Household _____

BACKGROUND INFORMATION:

Where are you originally from? _____

Number/Names of Siblings _____

Significant Family History _____

Education Level _____ Occupation _____

Veteran _____ What Branch? _____

Age at Retirement _____ Adjustment to Retirement (good/hard/how time was spent): _____

INTERESTS / HOBBIES: (Please check any / all that apply, describe where applicable.)

Life Skills

- Sewing / Knitting
- Cooking / Baking
- Cleaning
- Gardening / Floral Arranging
- Painting / Crafts
- Carpentry / Fixing Up
- Play Instrument _____
- Other _____

Group Interaction

- Music / Singing
- Trivia / Games
- Storytelling
- Books / Newspaper
- Pets _____
- Other _____

Physical

- Individual/Group Exercise
- Dancing
- Walking
- Group Exercise
- Travel _____
- Other _____

What are you known for being good at /interested in? _____

If you could do anything, what would it be? _____

COMMUNITY INVOLVEMENT: Member of any social organizations? (Rotary, Elks, religious, garden, bridge, clubs)

Did you participate in any community, volunteer or charitable organizations? _____

SOCIAL INFORMATION: Goals of family / participant: (socialization / stimulation, exercise, family respite, etc.)

Personality Traits / Social History: (introvert / extrovert, etc.)

PLEASE COMPLETE AND RETURN – 2 sides

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Office Use Only
Day(s) _____
Start _____
End _____

CAREGIVER/CONTACT PERSON INFORMATION

1. Caregiver _____ Email _____

Address/City/State _____ Zip/County _____

PHONE: Cell _____ Work _____ Home _____
(Mark a * by best daytime phone.)

2. Alternate contact person _____ Email _____

Address/City/State _____ Zip _____

PHONE: Cell _____ Work _____ Home _____
(Mark a * by best daytime phone.)

3. Participant Name _____ Birthdate _____ Date _____

Address/City/State _____ Zip/County _____

Living Arrangement _____

EMERGENCY INFORMATION

We are strictly a social model program. Below medical information is for EMS professionals only in case of emergency.

Doctor Name _____ Phone _____

Hospital Preference _____ Phone _____

Power of Attorney for Health Care Yes _____ No _____ Living Will Yes _____ No _____

Care Notes: List medical diagnoses/ any physical or dietary limitations / restrictions including food and drug allergies and/or any precautions:

How did you find out about Aloha/our program? _____

Transportation and other program payment assistance resources may be available.
www.alohatoaging.org or contact Aloha to Aging, Inc. at 770.722.7641 for more information.

PLEASE COMPLETE OTHER SIDE