VWCCOA SENIOR CENTER EMERGENCY CONTACT FORM

PLEASE SIGN IN AT THE KIOSK WHEN YOU VISIT THE SENIOR CENTER

Thank you for providing this information, which will receive the fullest measure of confidentiality. ***The consumer is responsible for notifying the VWCCOA of changes in pertinent medical information and changes to your emergency contact.***

Name: _____ Date of Birth: _____

Address: _____Email:_____

City: _____Zip:_____ Phone Number: _____

If I am involved in a medical emergency, please contact the following person(s):

Name: _____ Relationship:_____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

In case of an emergency, do you grant permission for us to contact and provide information to your emergency contacts? **(PLEASE INITIAL CHECK YES OR NO): _____YES _____NO**

Do you have any medical condition, or are you taking any medications we should be aware of in the event of an emergency? _____

Are you allergic to any medication, food, or insects? **_____YES _____NO**

_____

If you attend exercise classes, please ***PRESENT YOUR MEDICAL INSURANCE CARD TO THE FRONT OFFICE.***

Can COA notify you via text message? **_____YES _____NO**

Do you permit us to provide this information to the emergency/medical provider in an emergency? _____YES _____NO

Signature: _____ Date: _____