Membership & Medical Form for AgeWell Services

Please complete the following information. All information is confidential.

Name:					Phone:	( )
Address:					City:	
State:		Zip:		Birth Date * *(required)*	Mo. Day Year	

Emergency Contact Information			
Contact Name: Relationship to you:		Phone:	( )
Physician's Name:		Phone:	( )
Hospital Preference:			
List Medications Currently Taken & Dosage: (use back of page if needed)			
List Medication Allergies:			
List Food Allergies:			
List Special Health Information including chronic illnesses, surgeries, etc.:			

I understand that this information will be used in emergency situations ***only*** as a means to provide me with proper care in case of illness or accident. I understand that all expenses incurred in an emergency situation are my responsibility and not that of AgeWell Services and that it is my responsibility to update this form as changes in my information occur.
I understand that this information is considered **very** confidential and will not be used for any supplementary purposes. I ***authorize*** AgeWell Services to utilize any photographs, personal narrative, interviews or audio and video recording of my participation in any AgeWell Services event for any and all purposes to help promote the program.

☐Check if you do NOT want photos, etc. used.

E-Mail Address: *(optional)*			
Signature:		Date:	

****This form is required to participate in AgeWell Services activities***

Bring or mail to: AgeWell Services 560 Seminole, Muskegon, MI 49444
If you have any questions, please call **(231) 733-8643**