

Memory Care Respite of Florence

Participant's Full Name: _____

Participant's Preferred Name: _____

Home Address: _____

Mailing Address (if different from above) _____

Primary Number: _____ Secondary Number: _____

Date of Birth: _____

Primary Caregiver: _____ Secondary Contact Person _____

How did you hear about the Memory Care Respite Center of Florence?

Consent:

- As the family member/caregiver for the participant named above, I give my permission for her/him to participate in Coffee Club; the Adult Social Day Program for those experiencing memory impairment at Memory Care Respite of Florence (from here out called MCRF).
- I give my permission for MCRF to use our names or photographs to promote the program of respite care.
- I give permission for the above participant to go on any field trips or walks deemed appropriate by the volunteers at MCRF.
- I will not hold MCRF liable in case of accident or injury.
- I give MCRF permission to copy the participants COVID vaccine card.
- I understand that during the transition period needed by the above participant into the Coffee Club program that I must be within 15 minutes of the center in case my participant needs support..

Please initial one:

- _____ I am financially able to pay the fee requested for participating in the program.
- _____ I am unable to pay the fee for participation in the program and am requesting a scholarship.

Signed:

Signature

Relationship to participant

Date

EMERGENCY CONTACTS

Next of Kin Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____

Home Address: _____

Local Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____

Home Address: _____

PHYSICIAN: _____ **Phone:** _____

General Health

Diagnoses

Medications and What For

Allergies/Contraindications due to Medications

Self-Care Capabilities

Activity Level Considerations or Restrictions (e.g. transfer to & from chair; if the participant is a wanderer, are they registered with the Alzheimer’s Association “Safe Return” program?)

Toileting Considerations (e.g. on a schedule, assistance needed, use of incontinence products?)

Diet Considerations (e.g. help with eating, special foods or allergies?)

Special Needs: Please give any specific “helpful hints” or accommodations needed

Close Family Members and Friends

Occupation History

Current Household Members Including Pets

Hobbies & Special Interests

Favorites (colors, flowers, music, movies, places, etc)

Strengths

Frustrations and Behavior Patterns: What are the cues or triggers that may lead to frustration, anxiety, stress?

Special Input from Family

Close Family Members and Friends

Name	Relationship Where do they live? Recent contact?	Special story about their relationship

