Memory Care Respite of Florence

Participant's Full Name: _____

Participant's Preferred Name: _____

Home Address: _____

Email Address_____

Date of Birth: _____

Primary Caregiver: _____Secondary Contact Person_____

Primary Cell Phone: _____Secondary Number:_____

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 read each pair and 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.

- _____I give my permission for MCRF to use our first name, photos or videos to promote the program.
- _____I do not give my permission for MCRF to use our first name, photos or videos to promote the program.

Signed:

_____

Signature *Relationship to participant* *Date*

EMERGENCY CONTACTS

Next of Kin Name: _____ Relationship: _____
Home/Cell Phone (circle one): _____ Work Phone: _____
Home Address: _____

Local Contact Name: _____ Relationship: _____
Home/Cell Phone (circle one): _____Work Phone: _____
Home Address: _____

PHYSICIAN: _____ **Phone:** _____

General Heath

_____

_____

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?)

_____

_____

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

_____

_____

Close Family Members and Friends

Occupation History

Current Household Members Including Pets

Hobbies & Special Interests

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

Strengths

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

Special Input from Family

_____

_____

_____

Close Family Members and Friends

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