# IEA Brain Health Club
# Application Form

*Serving Upstate families challenged by dementia*

Full Name:_____Date:_____

Caregivers Name:_____Phone:_____

Address:_____

Birthday_____Marital Status: Married_____Single_____Divorced_____Widowed_____

Presently lives with_____

Contact email address:_____

How did you hear about program?_____

**ATTENDANCE:** Please check the day(s) that participant would like to regularly attend.

_____Monday ____Wednesday

**EMERGENCY INFORMATION:**

Doctor's Name_____Phone #_____

Address_____

**ALLERGIES**:_____

List all physical problems including mental health and communicable diseases:

_____

_____

_____

List any dietary or physical limitations:

_____

_____

List medications/dosages:

_____

_____

160 Commons Way
Central, SC 29630
stacey@pcmow.org
864.507.2254

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Caregiver Contact Information:

Caregiver's Name:_____Relationship:_____

Address if different than above:_____

Phone Numbers with area code: (Please * number to call first in emergency)

(H)_____(C)_____(W)_____

Alternate Contact:_____Relationship:_____

Phone Numbers with area code: (Please * number to call first in emergency)

(H)_____(C)_____(W)_____

Additional Comments:

_____

_____

_____

I,_____, have received and read a copy of the policies and procedures for IEA Brain Health Club.

Date:_____

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