AGE CONCERN – REGISTRATION FORM – HASSOCKS & DISTRICT

SURNAME: **TITLE (PLEASE CIRCLE): Dr. Mr. Miss. Ms. Mrs.**

FIRST NAMES (S): **DOB:**

ADDRESS:

POST CODE: **TEL NO:**

EMAIL ADDRESS:

Mobility (please circle):

Zimmer/ Wheelchair/ Crutches/ Walking Stick/ Hard of Hearing/ Visually Impaired

Are you (please circle):

Diabetic/Epileptic/Haemophiliac/On Warfarin/ Any Allergies:

Any dietary or medical requirement of which you feel we should be aware of?

Please complete the following detail. These will be used to contact a relative or friend if the need should arrive.

Emergency Contact 1	**Emergency Contact 2**
Name:	**Name:**
Relationship:	**Relationship:**
Tel Home:	**Tel Home:**
Tel Work:	**Tel Work:**
Tel Mobile:	**Tel Mobile:**

Name and Tel No of your Dr:

Reasons for using the centre (please circle):
Lunch/Transport/Chiropody/Hairdressers/Club/Group

Are you a: Volunteer/Staff Member

Any information will be stored under the Data Protection Act