**REGISTRATION FORM- AGE CONCERN – Hassocks & District**

**Surname: Title (please circle): Dr. Mr. Miss. Ms. Mrs.**

**First name(s): Date of Birth:**

**Address:**

**Post code: Tel. No:**

|  |
| --- |
| **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? (I.e. Vegetarian or Coeliac):** |

**Please complete the following details. These will be used to contact a relative or friend if the need should arise.**

**Emergency contact 1:** Name: **Home Tel: Work Tel:**

 **Mobile:**

**Emergency contact 2: Name: Home Tel: Work Tel: Mobile:**

 **Doctor:**  **Tel:**

**Reasons for using the centre: (*please tick*)**

**Lunch 🞏**

**Transport 🞏 Volunteer 🞏**

**Staff** **🞏** **Staff** **🞏**

**Chiropody 🞏**

**Hairdressers 🞏**

**Club/Group 🞏**