

ELDERWATCH PROGRAM

PARTICIPANT

Last Name:

First Name:

MI:

Address:

Phone:

Date of Birth: / /

Race:

Sex: M F

Height:

Weight:

Hair Color:

Eye Color:

Vehicle Information: Make:

Model:

Year

Color:

License #:

License State:

Special Needs or Considerations:

Wheelchair? Yes No

Oxygen in Home? Yes No

MEDICAL INFORMATION

Doctor's Name:

Phone #:

Hospital:

Chronic Illnesses:

Allergies:

Medication:

Vial of Life? Yes No

Church Affiliation:

DURABLE POWER OF ATTORNEY

Name:

Phone:

Address:

SOCIAL WORKER / AGENCY INFORMATION

Agency Name:

Case Worker:

Phone #:

Does Agency have a key to your home? Yes No

NEIGHBOR'S INFORMATION

Name: _____ **Does neighbor have a key to your home?** **Yes** **No**

Address: _____

Home Phone #: _____ **Work Phone #:** _____

Name: _____ **Does neighbor have a key to your home?** **Yes** **No**

Address: _____

Home Phone #: _____ **Work Phone #:** _____

RELATIVE'S INFORMATION

Name: _____ **Relationship** _____

Address: _____

Home Phone #: _____ **Work Phone #:** _____ **Key to home?** **Yes** **No**

Name: _____ **Relationship** _____

Address: _____

Home Phone #: _____ **Work Phone #:** _____ **Key to home?** **Yes** **No**

I am voluntarily participating in the ELDERWATCH Program. I understand that this is a cooperative program involving the West Central Illinois TRIAD, the Adams County 911 Center and area emergency service providers. With your participation in this program we will be able to better meet your needs and the needs of the community. Your signature below will allow us to share the information on this form with other agencies.

Signature: _____ **Date:** / /

Witness: _____ **Date:** / /

Return this form to any one of the three people listed below:

Elderly Service Officer 639 York Quincy, Il. 62301	Elderly Service Officer Quincy Police Dept. 110 South 8th Street Quincy, Il. 62301	Elderly Service Officer Adams County Sheriff's Dept. 521 Vermont Quincy, Il. 62301
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