MEMBER INFORMATION FORM

This information will only be shared with medical personnel in the event of an emergency.

Name: ______________________________________

Address: ______________________________________

____

Phone: ________________ E-mail: ___________________

Date of birth: ______________________________________

In case of emergency, please contact:

Name: ______________________________________

Phone: ________________Alternate: _________________

Relationship: ______________________________________

Hospital Preference:___________________________________

Medical Information:

Cause of aphasia: Stroke TBI Other: __________

Date of onset: ______________________________________

Allergies: ______________________________________

Medications: ______________________________________

____

Surgeries: ______________________________________

Other medical conditions: ____________________________

____

Doctor's Name: ______________________________________

Doctor's Phone:______________________________________

Doctor's Address:_____________________________________

Additional Information:

Please describe if you experience any weakness in your face, arms or legs:

____

____

Please describe if you experience limited range of mobility

____

____

Describe any vision problems. Do you wear glasses?

____

Do you wear hearing aids? YES NO

Highest level of Education:

____High School ____Some College

____Bachelor ____Masters/Doctorate

Is English your first language? YES NO

If not, what is: Spanish Other: _____________

Profession before Aphasia onset:

____

If there is an advanced directive in place, you may choose to attach a copy. By completing this information you are authorizing ***Aphasia Community Partners*** to provide this information to emergency service workers in the event of an emergency.

__________________ __________________

PRINTED NAME DATE

____

SIGNATURE OF PARTICIPANT OR LEGAL GUARDIAN

PERSONALITY QUESTIONNAIRE:

1. **In company do you:**

- wait to be approached, *or*
- initiate conversation?

2. **Are you inclined to be:**

- somewhat reserved, *or*
- easy to approach?

3. **At what times are you interested in participating?**

____ Flexible ____ Weekends ____ Weekdays
____ Evenings ____ Other: _________

4. **Interests (Circle All That Apply):**

- Seeing movies
- Going to museums (Morrill Hall, Quilt Museum, etc.)
- Outdoor activities (Fishing, hiking, taking walks, etc.)
- Going to restaurants/coffee/ice cream
- Music (Jazz shows, concerts, etc.)
- Crafting
- Playing card games
- Cooking
- Travel
- Sports
- Art
- Photography
- Going to the theatre/seeing plays
- Other: __________________________________

5. **How many hours a month (on average) would you like to participate?**

- 1 Hour
- 1-2 Hours
- 3-4 Hours
- 4+ Hours
- Other: ___________________

6. **How old are you?**

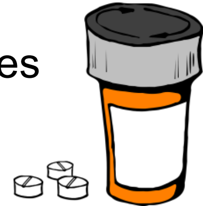
Please tick appropriate box	
• **18-21**	
• **21-34**	
• **35-44**	
• **45-54**	
• **55-64**	
• **65 and over**	

PARTICIPATION AGREEMENT

Your participation in the activities of *Aphasia Community Partners* is expressly conditioned upon your agreement to the following:

- You are responsible for your own self cares (this includes dressing, eating meals, ability to self-medicate and use the toilet independently).

- If you are unable to do the above mentioned cares independently, you will provide and have a **caregiver** with you **at all times** to assist you with your needs.



- You understand that if you have swallowing or other **medical issues**, you are responsible for maintaining your prescribed medical treatments, diets, and other meal modifications.

- You are physically, psychologically, and cognitively able to participate in outings.

- You are able to get along with others.

- You understand that you are responsible for your own transportation to and from the meeting location. Volunteers will not provide transportation.

If at any time there has been a change and you are unable to comply with the above, please notify us.

______________________________ ____________________

Printed Name Date

____

Signature of member or legal guardian

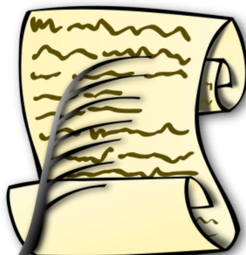
COMMUNITY OUTING WAIVER

____The member is responsible for
arranging travel to and from the selected outing destination

_____ The member understands community outing
destinations are to public areas/businesses accessible to the
general public

_____ The member understands that Aphasia Community Partners
is not responsible for community outing location **conditions**,
activities, or **third persons present** at the location.

_____ The member agrees to hold harmless *Aphasia Community
Partners* and its officers, employees, and volunteers for any
responsibility or liability.



_____ This includes claims/causes of action for demands or
injuries, including bodily injury, sustained or incurred, during or as
a result of my participation in this outing (including travel to and
from such) arranged outside of *Aphasia Community Partners*
premises.

______________________________ ____________________
Printed Name Date

____
Signature of participant or legal guardian

CONSENT TO PHOTOGRAPH

As a member of the Aphasia Community Partners Program, it is OK to:

____ Take my picture

____ Make a movie of me

____ Record my voice

___*John H. Hancock* Use my name

Aphasia Community Partners can use these recordings for:

- ✓ Teaching
- ✓ Training
- ✓ Publicity

YES _____

NO _____

____________________	____________________	____________
Printed Name	Signature: Participant or Guardian	Date