CITY OF SOLON ~ DEPARTMENT OF SENIOR SERVICES
35000 PORTZ PARKWAY, SOLON, OHIO – 440/349-6363
UPDATED EMERGENCY DATA –2019

Name: ______________________________
Last Name First Name Middle Initial

Address: ______________________________ Zip Code: ________

City: ______________________ Date of Birth: ________________

Phone: ( ) ______________________ Phone: ( ) ______________________

Email: ______________________

Each statement must be answered true (T) or false (F):

_______ **I am 60 years of age or older.**

OR

_______ ***FOR VAN TRANSPORTATION ONLY:*** **I am 21 or older and permanently disabled under the guidelines of the Social Security Administration.**

_______ **Proof of disability is attached.**

Marital Status:

☐ Single
☐ Married
☐ Partnered

Spouse/Partner's Name: ______________________

Completion of health and insurance information is not required for participation but helpful, in the event of an emergency. Waiver below must be signed and is required for participation.

PLEASE CHECK ALL THAT APPLY:

High Blood Pressure	☐	Heart Condition			☐
Stroke	☐	Pacemaker			☐
Hearing Aid or Hearing Problems	☐	Sight Problems			☐
Bridge/Dentures	☐	Wheelchair ☐		Walker	☐
Diabetes	☐	Insulin	Oral ☐	Injection	☐
Do you need special assistance	☐	Allergies:	Yes ☐	No	☐

Other (Explain): ______________________________

____

____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

7. ______________ 8. ______________ 9. ______________

Medicare # ______________ Medicaid # ______________

Other Hospitalization: ______________ Number ______________

Do you carry a hospital identification card with you? Yes ☐ No ☐

Doctor's Name: ______________ Phone Number: ______________

Hospital of Choice: ______________________________

CONTACT IN CASE OF EMERGENCY: ***(You must list two.)***

Name: ______________________ Relationship: ______________________

Day Time Phone: ____________________ PM Phone: ______________________

Name: ______________________ Relationship: ______________________

Day Time Phone: ____________________ PM Phone: ______________________

Do you have a living will? Yes ☐ No ☐

Do you have a medical power of attorney? Yes ☐ No ☐

Person holding medical power of attorney:

NAME: ______________________

PHONE: ( ) ______________________

The undersigned, hereby agrees for consideration of any Senior activities/programs/trips and/or van transportation services to be provided by the City of Solon; to hold harmless and release the City of Solon and its agents from any and all suits, claims or damages that may arise as a result of Senior activities/programs/trips and/or van transportation services rendered to the undersigned for his or her convenience and waive any claim on his or her own behalf arising from said City service.

______________________________ ______________
Signature **Date**

Revised 8-8-18