



# BRANDYWINE VALLEY ACTIVE AGING MEMBERSHIP/PARTICIPANT/VOLUNTEER APPLICATION

All participant information is kept strictly confidential. This information helps our staff provide you superior service and to best respond to your needs in an emergency. Information collected helps determine future funding.

## \*PERSONAL INFORMATION

How should we address you (check all that apply):  Mr.  Miss.  Mrs.  Ms.  Mx.  Dr.  Rev.  Hon.

*FIRST NAME (LEGAL):	*MIDDLE INITIAL:	*LAST NAME:	*NAME YOU GO BY:
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*LAST FOUR OF SSN:	*DATE OF BIRTH	*ESTIMATED INCOME	*ARE YOU A VETERAN
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## To show you the most respect possible, please let us know: do you think of yourself as?

Caucasian/White  Black/African American  Native American  Asian  Native Hawaiian/Pacific Islander  
 Hispanic or Latino  Non-Hispanic or Non-Latino  Other  
 Male  Female  Transgender  Nonbinary  Something else  
 Lesbian, Gay or Homosexual  Straight or Heterosexual  Bisexual  Something else  Do not know  
 Single  Married  Domestic Partnership  Divorced  Separated  Widowed  Something else  
**My pronouns are**  He/Him/His  She/Her/Hers  They/Them/Theirs  Something else

## \*CONTACT INFORMATION

*Home Address	*Mailing Address (if different from home)
_____	_____
_____	_____
County: _____	County: _____
Phone: _____	Municipality: _____
Cell/Mobile: _____	Email Address: _____
Municipality: _____	Do you live:
	<input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> In a Rural Area

## \*\*\* PLEASE TURN OVER AND COMPLETE THE REVERSE \*\*\*

## STAFF USE ONLY

Date Received: \_\_\_\_\_ Date Paid: \_\_\_\_\_  Cash  Charge  Check # \_\_\_\_\_  
 Participant (FREE)  Single (\$30.00)  Couple (\$45.00)  Under 50 (\$50.00)

## \*Emergency Contact (please provide two)

### \*Emergency Contact #1

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Cell/Mobile#: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

### \*Emergency Contact #2

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Cell/Mobile#: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

## \*Medical Information/History (attach additional page if necessary)

Allergies: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Medications (incl. prescriptions, over-the-counter, and vitamins)

Medication Name

Dosage

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Care Physician (Name & Phone Number)

Hospital Preference

\_\_\_\_\_

\_\_\_\_\_

## \*Participation Waiver and Waiver Consent

Individuals wishing to participate in programs provided by Brandywine Valley Active Aging (BVAA) should meet the following criteria to be considered appropriate for service:

- Able to feed and toilet themselves
- Oriented to current surroundings
- Be able to speak clearly and desire to participate
- Not at a risk for wandering
- Able to ambulate safely
- Behave in a non-aggressive, non-disruptive manner
- Able to self-administer any medications
- Free of any infectious disease that could put others at risk

Persons not meeting the criteria are welcome only if escorted by a responsible person always. BVAA is not responsible for monitoring the activities of anyone visiting or participating in programs or services. Staff reserves the right to make any final decision in all cases as to who is appropriate for service provision.

BVAA is a welcoming place for all people regardless of race, nationality, disability, religion, color, sex, sexual orientation, gender identity. As such, intolerant or hateful speech will not be tolerated. Offenders Will be asked to leave the premises.

**WAIVER CONSENT:** I wish to take part in one or more activities of Brandywine Valley Active Aging and, to the best of my knowledge, information, and belief, have no physical restraint which would prohibit my participant in activities. In consideration of my application being accepted, I am being legally bound, do hereby for myself, my heirs, my executors, and administrators, waive and release any and all rights I may have against BVAA, it's directors, officers, agents, staff (paid or volunteer) And any other co-sponsoring organizations for any and all injuries, claims, damages, or causes of action, suffered by me during my participation in the events at BVAA. BVAA has my permission to have emergency medical services, a physician, or other healthcare provider attend me if it is deemed necessary for my health, welfare, and/or safety. I attest and verify that I am in sufficiently good health for each activity. I hereby consent and agree that BVAA has the right to take photographs of me and to use those photographs in any and all media including my name and identity by descriptive text or commentary.



Signature: \_\_\_\_\_

Date: \_\_\_\_\_