



New Fairfield Senior Center

Registration Form

PLEASE PRINT

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS (if different) _____

PHONE NUMBER: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN EMERGENCY:

NAME: _____

PHONE - HOME: _____ WORK: _____ CELL: _____

HOW IS THIS PERSON RELATED TO YOU? _____

MEDICAL

ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER: _____

ANY MEDICAL CONDITIONS WE NEED TO BE AWARE OF:

Signature: _____ Date: _____

Completed emergency medical information is required for all New Fairfield Senior Center Trip participants

By signing you are giving the NFSC staff permission to use in case of emergency