Boxford Council On Aging
Activities Intake Form

Intake Date: _____ **Filled by:** _____

Participating Senior:

Name: _____ **DOB:** _____

Address: _____ **Phone:** _____
Street Address

_____ **Cell Phone:** _____
Street Address (add'l info)

_____ **Email Address:** _____
City State ZIP Do you wish to receive monthly Newsletter

Home Status: W/Family | Alone | Inlaw Apt | FMV **COA Newsletter:** Yes No
Circle One to Indicate Resident Status Do you wish to receive monthly Newsletter

Emergency Contacts:

Contact #1

Name: _____

Address: _____
Street Address

_____
City State ZIP

Telephone #: _____

Relationship: _____

Contact #2

Name: _____

Address: _____
Street Address

_____
City State ZIP

Telephone #: _____

Relationship: _____

Optional Medical Information:

Pref. Hospital: _____

File of Life: _____

Covid 19 Vaccine: **1st Dose Date:** _____

2nd Dose Date: _____

Disabilites:	**Oxygen**	**Dialysis**	**Other**	**Explain Other**
Yes				
No				

Notes: _____

_____

_____

Authorization: My personal phone information listed above can be shared with Boxford's Public Safety Agencies. Yes No Please circle one

Signature: _____ _____

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Name ***Date***