Boxford Council On Aging
Activities Intake Form

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

Participating Senior:

Name: _____ **DOB:** _____

Address: _____
Street Address

_____
Street Address (add'l info)

_____
City State ZIP

Phone: _____

email Address: _____

COA Newsletter: Yes No
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: _____

Disabilites:	Oxygen	Dialysis	Other	Explain Other
Yes				
No				

Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____