 Phone: (470)-251-4450

 Website: Ohana-day.org

 Email: donica@ohana-day.org

**INSTRUCTIONS:** Fill out all requested information in the shaded areas and boxes on this form and email to donica@ohana-day.org. Once form is received, we will contact you to schedule your free 2-hour visit.

**ON-LINE REGISTRATION FORM**

|  |
| --- |
| **APPLICANT INFORMATION** |
| First Name: Enter Text Here  | Last Name: Enter Text Here  | MI: Enter Text Here  |
| Address: (Street, City, State, Zip) Enter Text Here  |
| Phone Number: Enter Text Here | Email Address: Enter Text Here |
| Age:  | Male[ ]  Female[ ]  | Marital Status: [ ] Married[ ] Divorced[ ] Widow[ ]  Never Married[ ]  |
| Who does applicant live with? Enter Text Here | Relationship: Enter Text Here |
| **APPLICANT HEALTH HISTORY** |
| List any major health conditions: Enter Text Here |
| Primary Care Physician: Enter Text Here | Dietary Requirements: (please check)[ ] Regular[ ]  Low-sodium[ ]  Diabetic [ ]  Other, please specify: Enter Text Here  |
| Is supervision or help required with medications?(please check) [ ] No[ ] Yes If yes, please explain: Enter Text Here  |
| What assistance, if any, is required in the following areas: (please check applicable boxes and explain)[ ] Walking or Standing (Explain) Enter Text Here[ ] Toileting (Explain) Enter Text Here [ ] Bathing (Explain) Enter Text Here[ ] Eating (Explain) Enter Text Here |
| Requested Start Date: Click or tap to enter a date. | [ ] F/T (≥ 5hrs. daily)[ ] P/T (< 5hrs. daily) |
| Days Requested: (Please check) [ ] Mon [ ] Tue [ ] Wed [ ] Thurs [ ] Fri  |
| What additional special needs does the applicant have, if any? (i.e., need for socialization, supervision, medical assistance, wound changing, bathing…) Enter Text Here |
| Person completing this form: Enter Text Here | Contact Number: Enter Text Here |
| Relationship to Applicant: Click or tap here to enter text . | Email: Click or tap here to enter text.  |

**PLEASE EMAIL COMPLETED FORM to** **donica@ohana-day.org****. Thank you!**