CHESHIRE HOME SUMMERSTRAND
PART TIME RESIDENT'S DETAILS

TEMPORARY / DAY CARE

NAME: _____

SURNAME: _____

MR. ☐ MRS. ☐ MISS. ☐ MS. ☐

MARRIED: ☐ DIVORCED: ☐ SINGLE: ☐ WIDOWED: ☐ DEPENDENTS: YES / NO

ID NUMBER: _____

DATE OF BIRTH: _____

DATE OF ADMISSION: _____

ALLERGIES TO FOOD / MEDICINE:

_____

DIAGNOSIS:

_____

CURRENT TREATMENT:

_____

_____

MEDICATION:

_____

_____

_____

_____

_____

CURRENT HEALTH / PHYSICAL CONDITION (EG BRUISES, WOUNDS, SORES, LESIONS….) :

_____

_____

_____

NEXT OF KIN (1):

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

HOME TELEPHONE: (_____) _____

WORK TELEPHONE: (_____) _____

CELL NUMBER: _____

EMAIL ADDRESS: _____

NEXT OF KIN (2):

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

HOME TELEPHONE: (_____) _____

WORK TELEPHONE: (_____) _____

CELL NUMBER: _____

EMAIL ADDRESS: _____

FRIEND (NOT A RELATIVE):

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

HOME TELEPHONE: (_____) _____

WORK TELEPHONE: (_____) _____

CELL NUMBER: _____

IN CASE OF EMERGENCY CONTACT:

MEDICAL DOCTOR: _____

HOSPITAL: _____

DOCTOR'S ROOMS PHONE NO: _____

DO YOU HAVE A MEDICAL AID? YES ☐ NO ☐

WHICH COMPANY: _____

NAME OF MAIN MEMBER: _____

MEMBER NO: _____

AMBULANCE ARRANGEMENT IF APPLICABLE: _____

****AN INDEMNITY FORM MUST BE SIGNED AND SUBMITTED WITH THIS APPLICATION FOR TEMPORARY / SHORT STAYS / DAY CARE.**

SIGNED: _____ (APPLICANT / GUARDIAN) DATE: _____

SIGNED: _____ (CHESHIRE HOME MANAGER) DATE: _____