



**“Improving Socialization by
providing Meals and
Interaction to Impact the
Lives of Our Elders”**



DATE _____

Name (please print) _____

Street Address _____ Apartment/Unit # _____

City/State/Zip _____ Birthday: _____

Phone Number: _____ Best Time To Call _____ HARD Of Hearing? _____

Gender: _____ Race: White / Black / Hispanic / Native American / Asian / Unknown / Other _____

NOTES: _____

Emergency Contact Information

Name _____ Relationship: _____

Address (if different) _____

Primary Phone: _____ Alternate Phone _____

Allergies/Dental Concerns/Medical Issues/Dental

ALLERGENS: Peanuts Tree Nuts (Almonds, hazelnuts, walnuts, brazil, cashews, pecans, pistachios, macadamia, etc.) Dairy (Milk, Eggs, Yogurt) Gluten (wheat, barley, oats) Seafood/Crustacean (Fish, crabs, lobsters, oysters, Shellfish/Shrimp, etc.) Mustard Sesame Soybeans
 Other/Notes _____

DENTAL CONCERNS: (Dentures/Partials, Missing Teeth) _____

MEDICAL ISSUES: Diabetes High Blood Pressure Heart Conditions Obesity Stroke Cancer Dementia
 Diverticulitis/Diverticulosis Arthritis High Cholesterol Other _____

Food Preferences

PLEASE LIST ANY FOOD (MEAT, VEGETABLE, SIDE OR DESSERT) THAT YOU ABSOLUTELY DO NOT LIKE OR JUST WOULDN'T CARE TO HAVE:

(We are unable to guarantee that you will never receive something on your plate that you do not like, however we will attempt to try to keep your food dislikes to a bare minimum).

How This Works

Please initial that you understand each statement:

*Each participant will attempt to deliver one full homecooked meal each Friday between the hours of 12:30pm – 1:30 pm (this is the meal delivery window). _____ (*Unforeseen issues may affect the targeted delivery time)

*Participants will allow an i.SMILE volunteer to contact him/her by phone or by personal visit to follow up and discuss comments or concerns about the previous meal received. _____

* Participants and/or caregiver will agree to ensure that someone will be available during the meal delivery window each week or identify a neighbor to receive the meal if the participant is unable to be home. To ensure the nutritional quality of the meals and physical safety of the participants, VOLUNTEERS ARE ASKED NOT TO LEAVE MEALS ON THE PORCH. _____

Acknowledgements, Disclaimers and Signatures

I agree that the information provided is true and complete to the best of my knowledge. _____

ALLERGENS: I acknowledge that despite every precaution that could possibly be made, there still may be a chance that a food item may contain or come in contact with common allergens, such as dairy, eggs, wheat, soybeans, tree nuts, peanuts, fish, shellfish, wheat, or any other allergen previously identified. _____

I [DO / DO NOT] give permission to take photographs and / or video of my [_ myself _participant _ other family members], giving full rights to use the images resulting from the photography/video filming, and any reproductions or adaptations of the images for fundraising, publicity, or other purposes to help promote the Common Ground Café's purpose, mission and vision _____.

Participant/Caregiver Signature _____ Date: _____

CGC Representative _____ Date: _____

*Please scan and email this form to commongroundcafenc@gmail.com or send the form to CGC, PO Box 672, Shelby, NC 28151.

If you have any questions about this form, please call our office at 704.981.0991.

Thank you for your interest in the Common Ground Café iSMILE Senior Meal Program.

Feel free to visit us online at www.commongroundcafenc.org