Carteret Health Department

Office on Aging

61 Cooke Ave. Carteret, NJ. 07008

732-541-3890

EVERYTHING MUST BE COMPLETELY FILLED OUT

First Name: ______________________ Last Name: ______________________

Street: ______________ City/Zip: ______________

Telephone: ___________ Email: ____________ Social Security # ____________

Date of Birth: ______ Age: ___ Weight: ___ Height: ___ ☐ Male ☐ Female

Emergency Contact: __________________ Relationship: ______________

Telephone: ______________ Work Phone: ______________

Doctor: __________ Phone: __________ Address: ______________________

The Following Information of for Statistical Purposes Only (Must Be Completely Filled)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Residence: ☐ Own Home ☐ Rent ☐ Live w/ Family ☐ Other: _______

Primary Means of Transport: ☐ Senior Bus ☐ Own Car ☐ Family/Friend ☐ Other: _______

Employment Status: ☐ Employed ☐ Retired ☐ Seeking Work ☐ Other: _________

Languages Spoken other than English: ______________

Are you member of another Senior Organization: ____________

Would you like to volunteer for the Carteret Senior Program: ☐ Yes ☐ No

Income Level: ☐ Below $11,770 ☐ Above $11,770

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ Other: _____

Additional Health Information:

____

____

____

Signature: ______________________ Date: ______________

For Office Use Only:

ID: ______ Date: ______ Trans: ______ Soc.Svcs: ______ Senior Meals: __________

Employee Intake: ______________________________ Date: ______________

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Medical Emergency Form

First Name: ______________________________ Last Name: ____________________________

Street: ____________________ City/State: ________________________ Zip: ____________

Telephone: ________________ Email: ___________________________

Allergies: ____

Blood Type: ______________

List Primary Health Concerns:

____

____

____

Doctor: _______________________________ Telephone: ____________________________

Street: _________________________ City/State: ___________________ Zip: ____________

Emergency Contact:

Name: _________________________________ Phone: ________________________________

Additional Contact:

Name: _________________________________ Phone: ________________________________

Print Name: ____

Signature: _______________________________________ Date: ____________

Thomas Sica
President

Linda Kimball
Vice President

John Narowitz
Jonathan D'Orsi
Susan Naples
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Lester Jones
Health Officer

Taqualla Lowman
Director

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Jorge Diaz
Councilman

Dennis DiMascio
Councilman

A.J. Johal
Councilman

Randy Krum
Councilman

Susna Naples
Councilwoman

HOLD HARMLESS & INDEMNIFICATION AGREEMENT

I, ________________________________, am of legal age, do hereby freely declare the following:

It is agreed that I will hold the Borough of Carteret, past, present or future officials, offices, successors, assigns, agents, employees and/or administrators harmless from any and all judgments, awards, debts, reckonings, promises, damages, demands and/or claims of any kind or nature whatsoever, including attorney's fees and costs, in any way related to my participation in any of the Borough of Carteret Office on Aging programs, conducted by members of the Borough of Carteret Health Department and/or Borough of Carteret Office on Aging.

This agreement may not be orally changed and shall be binding on the parties' successors and/or assigns.

Signed: ____
(Signature)

Date: ____________________