



# PARTICIPANT EMERGENCY INFORMATION FORM

## Contact People (2) - (At least one local)

1. \_\_\_\_\_  
Name Relationship Telephone Number  
Address: \_\_\_\_\_  
Street City State Zip Code

2. \_\_\_\_\_  
Name Relationship Telephone Number  
Address: \_\_\_\_\_  
Street City State Zip Code

Doctor: \_\_\_\_\_  
Telephone Number  
Address: \_\_\_\_\_  
Street City State Zip Code

Health Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications Currently Taken: \_\_\_\_\_  
\_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_  
\_\_\_\_\_

Update emergency information every 6 months if needed.

Updated:    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
                  M    D    Y                    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
  M    D    Y                    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
  M    D    Y

Fill in all sections

# Determine Your Nutritional Health



- Read the statements below.
- Circle the number under "Yes" in the first column for those that apply to you.
- For each "Yes" answer, score the number in the box. **Total your nutritional score.**

**YES    NO**

<b>I (or someone close to me) have an illness or condition that has caused me to change the amount and / or kind of food that I eat.</b>	<b>2</b>	
<b>I eat fewer than two meals per day.</b>	<b>3</b>	
<b>I eat few fruits and vegetables per day.</b>	<b>2</b>	
<b>I eat or drink few milk products (e.g. milk, yogurt, cheese) a day.</b>	<b>2</b>	
<b>I drink less than 5 (8-oz.) cups of fluids a day (e.g. water, tea, juice).</b>	<b>2</b>	
<b>I have three or more drinks of beer, wine, or liquor almost every day.</b>	<b>2</b>	
<b>I have tooth or mouth problems that make it hard for me to eat.</b>	<b>2</b>	
<b>I don't always have the money to buy the food I need.</b>	<b>4</b>	
<b>I eat alone most of the time.</b>	<b>1</b>	
<b>I take 3 or more different prescribed or over-the-counter drugs a day.</b>	<b>1</b>	
<b>Without wanting to, I have lost or gained 10 pounds in the last six months.</b>	<b>2</b>	
<b>I am not always physically able to shop, cook, and / or feed myself.</b>	<b>2</b>	

<b>Total your nutritional score</b>	<b>Total</b>	
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**If your score is ...**

<b>0-2</b>	<b>Good! Re-check your nutritional score in six months.</b>
<b>3-5</b>	<b>You are at <u>MODERATE</u> nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center, or health department can help.</b>
<b>6 or more</b>	<b>You are at <u>HIGH</u> nutritional risk. Bring this checklist the next time you see your doctor, dietitian, or other qualified health or social services professional. Talk to him or her about any problems you may have. Ask for help to improve your nutritional health.</b>

**Remember - that warning signs suggest risk, but do not represent diagnosis of any condition.**

<b>Name</b>	<b>Date</b>
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Print  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_