



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Healthy Living Programs Questionnaire

Participant Information

Name: _____ Today's date (MM/DD/YYYY): _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Preferred phone: (_____) _____ (home/cell)

Alternate phone: (_____) _____ (home/cell)

Email: _____

Emergency Contact Information

Name: _____ Relationship: _____

Preferred phone: (_____) _____ (home/cell)

Alternate phone: (_____) _____ (home/cell)

Physician Information

Primary physician: _____ Phone: (_____) _____

Other physicians involved in your treatment/care: (use reverse side if necessary)

Name	Specialty	Phone number
_____	_____	(_____) _____
_____	_____	(_____) _____
_____	_____	(_____) _____

Which Healthy Living Program are you interested in?

- | | |
|---|--|
| <input type="checkbox"/> ACT! Youth Weight Management | <input type="checkbox"/> Healthy Ways: Adult Weight Management |
| <input type="checkbox"/> Delay the Disease: Parkinson's Disease | <input type="checkbox"/> OneStep: Multiple Sclerosis |
| <input type="checkbox"/> Diabetes Prevention | <input type="checkbox"/> THRIVE: Cancer Wellness Program |

Please return your completed form to the JKR Branch Member Services Desk.