



Mifflin-Juniata Area Agency on Aging, Inc.
Prime Time Health Program

REGISTRATION FORM

Date:			
First Name:		Middle Initial:	Last Name:
Gender:		Home or Mobile Phone #:	
Date of Birth:		Social Security # (must have at least the last 4 digits for participation):	
Residential Address:			Town
State	Zip Code	County	Municipality
Mailing Address (if different from residential):			Town
State	Zip Code	County	Municipality
Ethnicity (Check one or more boxes):			
<input type="checkbox"/>	American Indian/Native Alaskan	<input type="checkbox"/>	Non – Minority (White, non-Hispanic)
<input type="checkbox"/>	Asian	<input type="checkbox"/>	Other
<input type="checkbox"/>	Black/African American	<input type="checkbox"/>	White – Hispanic
<input type="checkbox"/>	Native Hawaiian/Other Pacific Islander	<input type="checkbox"/>	
Emergency Contact Name:		Phone #:	
Relationship to Emergency Contact: Spouse Son Daughter Friend Other: _____			
In Poverty (Do you earn less than \$11,770 a year?): Y or N			
Disabilities? (circle any that apply): Y or N			
Please circle any that apply: Physical Mental Emotional Social Other: _____			

Thank you for participating in our program. We hope you have an enjoyable time.