California Clubhouse

Membership Application

California Clubhouse
210 Industrial Rd. Ste 102, San Carlos CA 94070
650-539-3345
californiaclubhouse.org

Welcome to California Clubhouse!

To apply for membership to California Clubhouse, potential applicants need to have one of the following four diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder.

Please complete the following application, to begin our membership process.

Prospective Member Information

Name: _____ Today's Date: _____
First MI Last

Date of Birth: _____/_____/_____ Preferred Pronoun: _____ (e.g. he/his, she/her, they/their etc...)

Preferred Language:_____

Address: _____

City: _____ State:___ Zip:_____ County: _____

Phone: ____-____-_____ Cell: ____-____-_____ E-mail: _____

How can we best contact you? (circle one): Phone Cell Text E-mail

How did you hear about us?: _____

For in-house use only:

Date Inputted in Database: __/___/___

Medical Information

We gather medical information for emergency, logistical and statistical purposes. All information will be kept confidential. No information will be released without your consent.

Mental Health Diagnosis (check all that applies):

___ Schizophrenia ___ Schizoaffective Disorder
___ Bipolar Disorder ___ Major Depressive Disorder

Medical History

Please provide medical conditions that you have (ex. high blood pressure, diabetes, asthma, Crohn's disease, etc.):

_____

_____

Allergies and Dietary Restrictions:

California Clubhouse strives to provide lunch to all members daily. However, if you have any allergies to certain foods or have special dietary preferences, you are welcome to bring your own lunch.

_____

_____

Please note: California Clubhouse may have programs which may include strenuous physical activities (e.g. exercise). As a member, you are responsible for checking-in with your health care provider with regards to your level of involvement.

Emergency Contact Information

Emergency Contact Person: _____
Relationship to Member: _____ Phone: _____

Primary Care MD: _____
Agency: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Other Health Care Provider: _____
Phone: _____ Agency: _____
Address: _____
City: _____ State: _____ Zip: _____

Prospective Member Signature Date

Name & Title of Person Accepting Application Date