Information Form

Please PRINT, SIGN AND COMPLETE the entire form. All Participant information provided is strictly confidential. Information required for funding is noted with * *.

***Date*:** ____________ **Please check one:** **Consumer** ____ **New Member** ____ **Renewal** ____

	Last	(Jr., Sr. etc.)	First	Middle or Initial	Name you go by
Name					

	Street	Apt/Rm #	City	State	Zip Code
Address					

Municipality* (Township or Borough)** ____________ ***County ____________

Phones | Home Phone | Cell Phone

Newsletter by Email ____ Yes ____ No

Email Address ____________

***Social Sec. # *** XXX/XX/______(last 4 digits only Required by Commonwealth of PA)

Gender ____ Male ____ Female

Date of Birth ____________

Age Group ____ 60-64 ____ 65-74 ____ 75-84 ____ 85+ ____ Under 60

Marital Status
____ Married Spouse's Name: ____________
____ Single ____ Divorced
____ Separated ____ Widowed

Ethnic Race
____ African American
____ American Indian/Native Alaskan
____ Caucasian (White) ____ Asian
____ Hispanic Origin

Ethnicity
____ Non-Hispanic ____ Hispanic

Income Level
____ Single - Under $1,040/mo or $12,490/yr or Two People - Under $1409/mo or $16,910/yr
____ Between $12,490-$29,000/yr ____ Over $29,000/yr

Live Alone ____ Yes ____ No ***High Nutritional Risk*** ____ Yes ____ No ***Rural* (not in town)** ____ Yes ____ No

Caregiver for OASC Consumer? ____ Yes ____ No **See other side for:** **Volunteer?** **Medical Information**

Emergency Contact Information (Please provide two contacts)

	Name of contact	Phone #	Phone #	Relationship
1.				
2.				

Information & Assistance (I&A)

Do you have any concerns you wish to speak to the I&A person about?

____ Transportation ____ Register for Chester County Senior Transportation - Rover
____ Medicare ____ Insurance ____ Non-Driver ID
____ Prescriptions ____ Food
____ Other ____________

***** PLEASE TURN OVER, MORE QUESTIONS, READ AND SIGN ON OTHER SIDE *****

For Office Use Only

Annual Membership Donation of $15.00
Amount Paid ____
Date Paid ____
Renewal Date ____
Consumer ____
Member ____
Input Date
Database ____ Copilot ____
Member ID ____ Initials ____

Information Form

Name	Last	(Jr., Sr. etc.)	First	Middle	Name you go by

Volunteer Opportunities

Are you interested in volunteering here at the Center? ________ Yes _______ No

Medical Information

Physician's Name ____________________ **Phone #** ____________________ **Phone #** ____________________

Medical Condition(s) (Please Print)

____

____

Medications/Prescriptions (Please Print. No Dosage information needed.)

____

____

Allergies/Precautions/Special Concerns ______________________________

Participation Policy and Waiver Consent

Individuals wishing to participate in programs held by the Oxford Area Senior Center, Inc. (the Center) should meet the following criteria to be considered appropriate for service provision:

- Capable of feeding and toilet themselves independently
- Oriented to their current surroundings
- Behave in a non-aggressive and non-disruptive manner
- Desire to participate in a program or activity that is appropriate for them
- Be able to speak clearly and socialize with others
- Demonstrate consistent hygiene practices
- Be able to ambulate safely

A complete copy of the Participants' Rights Policy and Participation Policy will be made available at the request by a participant or participant's family member.

Persons not meeting these criteria are welcome only if escorted by a responsible person at all times. This is required for the well being of all participants and staffing participating in Center activities on or off the premises. The Center is not responsible for monitoring the activity of anyone visiting and/or participating in services or programs on or off the premises. The Executive Director, or in his/her absence a designated staff person, has the authority to make final decisions in all cases as to who is appropriate for participation in Center activities.

I wish to take part in one or more events of the Oxford Area Senior Center (the Center) and, to the best of my knowledge, information and belief, have no physical restraints, which would prohibit my participation in the events. In consideration of my application for participation being accepted, I being legally bound, do hereby for myself, my heirs, my executors and administrators, waive and release any and all my rights I may have against the Center, its directors, officers, agents, staff (paid or volunteer) and any other co-sponsoring organizations for any and all injuries, claims, damages or causes of action, suffered by me during my participation in the events of the Center. The Center has my permission to have a physician attend me if it is deemed necessary for my health, welfare and safety. I attest and verify that I am in sufficient good health for each activity, and my physical condition has been verified by a licensed physician. I have further read and understand the participation guidelines of the Center.

Signature: ________________________________ *Date*:______________________

FOR INFORMATION REGARDING OUR INFORMATION AND ASSISTANCE SERVICES, THE CHESTER COUNTY DEPARTMENT OF AGING SERVICES AND THE OXFORD AREA SENIOR CENTER, PLEASE SEE OUR HOSTESS OR A STAFF MEMBER.

REVISED 7/2019