

**YOU MUST BE A RESIDENT OF THE CANAL WINCHESTER SCHOOL DISTRICT TO PARTICIPATE
CANAL WINCHESTER SENIOR TRANSPORTATION PROGRAM
Client Information Sheet**

Name: _____

Street Address: _____

City/State/ZIP _____

County _____ Township (if applicable) _____

Phone: _____ (H) _____ (W) _____ (Cell)

*Date of birth _____ *Current Age _____ (if under 60, certification of disability must be attached)

*Gender: M F *Race: Black White Other *Is English your primary language? ____yes ____no

**The Senior Transportation Program does not discriminate against its clients. This information is required for statistical purposes.*

IN CASE OF EMERGENCY, NOTIFY: _____

Address: _____ Relationship: _____

Phone: _____ (H) _____ (W) _____ (Cell)

MEDICAL INFORMATION:

Physician (1) _____ Phone: _____

Address: _____

Physician (2) _____ Phone: _____

Address: _____

Relevant medical/behavioral information: _____

e.g. Seizures/diabetes/heart problems

Are you able to step into the van? ____yes ____no

If no, why are you unable to walk? _____

Do you have a standard wheelchair? ____ yes ____ no. Is it electric? ____yes ____no

Do you need a caregiver to accompany you (see client guidelines for details)? ____yes ____no

How often do you anticipate needing transportation? To where? _____

How did you find out about the program? _____

- For use by senior transportation program staff -

Wheelchair/lift van needed? ____yes ____no Caregiver needed? ____yes ____no

Canal Winchester School District resident? ____yes ____no

Approved ____yes ____no _____

staff signature

date