CANAL WINCHESTER SENIOR TRANSPORTATION PROGRAM
Client Information Sheet

Name: _____

Street Address: _____

City/State/ZIP: _____

County: _____ Township: _____

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

*Date of birth _____ *Current Age _____

*Gender: M F *Race: Black White Other *Is English your primary language? _____yes _____no

***We do not discriminate against our clients however his information is required for statistical purposes required by our funders.

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:
_____(EX: Seizures/Diabetes/Heart Problems, etc.)

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 (Please note: We are unable to transport clients who must remain in their wheelchairs and have a combined weight exceeding 600lbs.)

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 Daily Transportation: _____yes _____ no Special Trip only: _____yes

Staff Signature: _____ Date: _____