Information Form

Oxford Area Senior Center

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:** ____ **New Participant** ____ **Update**

	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) _____ (Mobile/Cell Phone)

Newsletter? ____ Mail ____ Email

Email Address _____

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

Date of Birth _____

Birthday In Newsletter ____ Yes ____ No

Age Group

____ 60-64 ____ 65-74

____ 75-84 ____ 85+ ____ Under 60

Marital Status

____ Married Spouse's Name: _____

____ Single ____ Divorced

____ Separated ____ Widowed

Ethnic Race

____ Asian

____ Black/African American

____ American Indian/Native Alaskan

____ Caucasian (White)

____ Hispanic Origin

____ Biracial

Ethnicity

____ Non-Hispanic ____ Hispanic

***Gender assigned at birth *** ____ **Female** ____ **Male**

*** Gender Identity ***

____ Female ____ Male ____ Non-Binary

____ Transgender Female (male to female)

____ Transgender Male (female to male)

____ Other, Specify _____

____ Choose not to disclose

Income Level

____ One Person - Under $1,215/mo or $14,580/yr ____ Over $35,000/yr

____ Two People - Under $1,614/mo or $19,720/yr

Living Situation

____ Alone ____ With Spouse ____ With Relative ____ With Friend ____ Other

Years living at same address

____ 0-5 ____ 6-10 ____ 11-20 ____ Over 20

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

Turn over for: **Medical Information, Volunteer Opportunities & sign form** **Caregiver for OASC Consumer?** ____ Yes ____ No

Emergency Contact Information (Please provide two contacts)

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

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

***** For Office Use Only *** Do not write below this line**

Annual Participation Contribution of $15.00

Amount Paid _____ Date Paid _____ Renewal Date _____

Database _____ Copilot _____

ID _____ Initials _____

Information Form

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

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 7/2023**