Information Form

Oxford Area Senior Center

Please **PRINT, SIGN AND COMPLETE** the entire form. All Participant information provided is strictly confidential. Items marked with ** are required for funding. **PRINT AS NEATLY AS POSSIBLE**

***Date*:** _____ **Please check one:** ☐ New Participant ☐ Update

Name Last _____ Jr., Sr. _____ First _____ Middle or Initial _____ Preferred name (if different) _____

Address Street _____ Apt/Rm # _____ City _____ State _____ Zip Code _____

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

Phones Home Phone _____ Mobile/Cell Phone _____

Newsletter Pickup: ☐ Yes ☐ No Online: ☐ Yes ☐ No Email: ☐ Yes ☐ No

Email Address: _____
PRINT AS NEATLY AS POSSIBLE

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

Date of Birth _____

Gender assigned at Birth ☐ Female ☐ Male

Birthday in Newsletter ☐ Yes ☐ No

Gender Identity
☐ Female ☐ Male ☐ Non-Binary
☐ Transgender Female (male to female)
☐ Transgender Male (female to male)
☐ Other, Specify: _____
☐ Choose not to disclose

Age Group
☐ 60–64 ☐ 75–84
☐ 65–74 ☐ 85+
☐ Under 60

Marital Status
☐ Married ☐ Single ☐ Divorced
Spouse's Name: _____
☐ Separated ☐ Widowed

Income Level

One Person	Two People
☐ Under $1,350/mo - $16,200/yr	☐ Under $1,823/mo - $21,876/yr
☐ Over $35,000/yr	☐ Over $35,000/yr
☐ Between the above amounts	☐ Between the above amounts

Ethnic Race
☐ American Indian / Native Alaskan
☐ Asian
☐ Black / African American
☐ Native Hawaiian / Other Pacific Islander
☐ Caucasian (Non-Minority White)
☐ Hispanic Origin
☐ Biracial

Living Situation
☐ Alone ☐ With Friend
☐ With Spouse ☐ Other
☐ With Relative

Years living at same address
☐ 0–5 ☐ 11–20
☐ 6–10 ☐ Over 20

High Nutritional Risk ☐ Yes ☐ No

***Rural* (not in town)** ☐ Yes ☐ No

Ethnicity ☐ Non-Hispanic ☐ Hispanic

Caregiver for OASC Consumer? ☐ Yes ☐ No

Emergency Contact Information (Please provide two contacts)

	Name of contact	Phone: ☐ Home ☐ Cell ☐ Work	Phone: ☐ Home ☐ Cell ☐ Work	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 Voluntary Participation Contribution of $15.00
Amount Paid _____ Date Paid _____ Renewal Date _____
Database ID _____ Copilot Initials _____

Information Form

Name	Last	Jr., Sr.	First	Middle or Initial

Volunteer Opportunities

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

Medical Information

	Physician's Name	Phone #	Phone #
1.			
2.			

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.

People who do not meet these criteria are welcome only if always escorted by a responsible person. 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. I authorize the Center to obtain medical assistance for me if needed. I confirm that I am in good health for all activities and that my condition has been verified by a licensed physician. I have read and understand the Center's participation guidelines.

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.