

**PHOENIXVILLE AREA SENIOR CENTER PARTICIPANT INFORMATION FORM**

PLEASE PRINT

All Participant information provided is strictly confidential

\*REQUIRED\*

PLEASE SELECT ONE: RENEWAL NEW PARTICIPANT

Today's Date \_\_\_\_\_

\*Name\* \_\_\_\_\_  
Last First Middle Initial

\*Date of Birth\* \_\_\_/\_\_\_/\_\_\_ \*Social Security #\* XXX-XX-\_\_\_\_ (last 4 digits only - required by PA) \*Gender\* \_\_\_\_\_

\*Mailing Address\* \_\_\_\_\_  
Street

\*Mailing Address\* \_\_\_\_\_  
City State Zip Code

\*Municipality\* \_\_\_\_\_ \*County\* \_\_\_\_\_

Residential Address (\*if different than mailing address\*) \_\_\_\_\_  
Street

Residential Address (\*if different than mailing address\*) \_\_\_\_\_  
City State Zip Code

\*Home Phone\* (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ License Plate # \_\_\_\_\_

\*Marital Status\* \_\_\_\_\_ \*Email Address\* \_\_\_\_\_

Fitness Plan (select one)	Silver Sneakers	Renew Active	Fitness Plan ID _____
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Emergency Contact

\*Name\* \_\_\_\_\_ \*Daytime Phone\* (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Medical Condition (Please print.) Medications/Prescriptions (Please print. Names only, dosage not required.)

1. \_\_\_\_\_ / \_\_\_\_\_

2. \_\_\_\_\_ / \_\_\_\_\_

Allergies/Precautions/Special Concerns \_\_\_\_\_

Disabilities/Limitations \_\_\_\_\_

\*Veteran/Military Service\* (select one) Yes No \*Nutritionally at Risk\* (select one) Yes No \*Frail\* (select one) Yes No

Yearly Income ( <b>select only one</b> ) **Income Levels are for grant and funding use only**						
<b>Single</b>	Under \$15,061	\$15,061-27,861	\$27,862-30,120	\$30,121-39,084	\$39,085-65,266	Over \$65,267
OR						
<b>Couple</b>	Under \$20,441	\$20,441-37,814	\$37,815-40,880	\$40,881-59,724	\$59,725-96,073	Over \$96,074

*Ethnicity/Race* (select all that apply)	Hispanic	Non-Hispanic	American Indian/Native Alaskan	Asian
	Black/African American	Caucasian (White)	Native Hawaiian/Other Pacific Islander	Multiracial

*Ethnicity/Race* (select all that apply)	Hispanic	Non-Hispanic	American Indian/Native Alaskan	Asian
	Black/African American	Caucasian (White)	Native Hawaiian/Other Pacific Islander	Multiracial

Do you need to register with Chester County Senior transportation (select one) Yes No

\*Living Situation\* (select one) Alone With Spouse With Relative With Friend Other

\*Years living at same address\* (select one) 0-5 6-10 11-20 Over 20

Signature required. Please turn over, read, and sign on other side.

**PHOENIXVILLE AREA SENIOR CENTER PARTICIPANT INFORMATION FORM**

Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Last First

The Phoenixville Area Senior Center (PASC) has written policies on the Privacy Act and will make copies available to all members of the organization upon their request. My signature on this registration form is confirmation that a copy of that document has been made available to me. Participant’s Initials \_\_\_\_\_

PASC reserves the right to use photos of member activities in its publications, on its website, and social media. By signing this registration form, I am giving PASC consent to use my photograph in its publications, on its website, and social media. Participant’s Initials \_\_\_\_\_

PASC may contact me or my contacts with information on upcoming events or fundraising efforts. PASC will not share my information with any other entity without my consent. Participant’s Initials \_\_\_\_\_

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

**Participation Policy and Waiver Consent**

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

- Capable of feeding and toileting themselves independently
- Oriented to the 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 (For the safety of all visitors, it is mandatory to use the elevator if you have been identified as a potential fall risk. Your safety is our utmost priority. Please use the elevator instead of the stairs if you have concerns about falling.)



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 Phoenixville 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 participation in the events of the Center. The Center has my permission to have a physician attend me if it is deemed necessary or 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.**

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Signature Required)