Meals On Wheels

REGISTRATION FORM

INTERIOR COMMUNITY SERVICES
ENRICHING LIVES, STRENGTHENING COMMUNITIES

REGISTRANT INFORMATION		
Client Name:		
Delivery address:		
City:	Province:	Postal Code:
Phone:	Date of birth:	
Billing Address:		
City:	Province:	Postal Code:

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		
Relationship:		
Address:		
City:	Province:	Postal Code:
Telephone:		

HEALTH INFORMATION
Hearing: Good_____Fair_____Poor_____
Sight: Good_____Fair_____Poor_____
Mobility: Good_____Fair_____Poor_____
Mental Status: Good_____Forgetful_____Confused_____Alzheimer's_____
Additional Information (if required):

DIETARY RESTRICTIONS OR REQUESTS (CHECK ALL THAT APPLY)		
Regular meals		Require help setting up meals: Yes____No_____
Diabetic		Interested in Standing Orders: Yes____No_____
Lactose intolerant		
Gluten intolerant		
Allergies:		

DELIVERY INSTRUCTIONS
Delivery instructions:
By signing below, you agree to ensure your account balance is paid in full. Meals will not be ordered if your account status does not remain current.

Signature of applicant:	Date
Signature of co-applicant, if required:	Date

FOR ADMINISTRATIVE PURPOSES:	Delivery Area: N1 N2 S1 S2