



Kendall Area Transit Registration Form
Rider Intake Form
Child(ren)

Phone: (877) 446-4528 Fax: (815) 981-4187



Please fill out both sides of this form.

Rider Information			
First Name:		Middle Initial:	Last Name:
Phone (for reminder calls):	Second Phone:		Email:
Home Address, City, State, Zip:			County: Date of Birth:
Would you like a reminder phone call the evening before your trip? Yes No		In the event of a closing, how would you like to be contacted?	
Would you like to receive an "On Our Way" phone call? Yes No		Text Voice Recording No Thanks	
Demographic Information			
Please check ALL that apply:			
Race: <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Other		Ethnic Origin: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino Limited English Speaking: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Gender: M / F Primary Language: _____	
Special Assistance Needed			
Please check ALL that apply:			
<input type="checkbox"/> Blind <input type="checkbox"/> Cognitive Behavior <input type="checkbox"/> Deaf <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Mobility Device <input type="checkbox"/> Oxygen		<input type="checkbox"/> Physical Impairment <input type="checkbox"/> Service Animal <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Under Eight <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Wheelchair/Scooter	
		<input type="checkbox"/> Wheelchair -Oversized <input type="checkbox"/> Powerchair	
Please Note any Health Issues or Allergies: _____ _____ _____ _____			
Parental Contact Information (Required if Under 18)			
Full Name: _____		Relationship: _____	
Cell Phone: _____		Home Phone: _____ Work Phone: _____	
Address, City, State, Zip: _____		Email: _____	
Full Name: _____		Relationship: _____	
Cell Phone: _____		Home Phone: _____ Work Phone: _____	
Address, City, State, Zip: _____		Email: _____	
Emergency Contact Information			
1. Emergency Contact Name: _____		Relationship: _____	
Phone: _____		Second Phone: _____	
2. Emergency Contact Name: _____		Relationship: _____	
Phone: _____		Second Phone: _____	
For Rider's Under 18 - Please indicate a <u>Safety Word</u> that will be required of ANY contact attempting to make a schedule change:			

Reoccurring Travel Locations (i.e. Medical, School, Work, Other)

Site 1 Name: _____ Contact Onsite Full Name: _____

Address, City, State, Zip: _____ Reason for Travel: _____

Special Directions for finding the location: _____

Site 2 Name: _____ Contact Onsite Full Name: _____

Address, City, State, Zip: _____ Reason for Travel: _____

Special Directions for finding the location: _____

Site 3 Name: _____ Contact Onsite Full Name: _____

Address, City, State, Zip: _____ Reason for Travel: _____

Special Directions for finding the location: _____

Summarize Travel Needs & Schedule (please include times for pick-up/drop-off, days of the week, length of need)**How did you find out about KAT?** _____

Signature of Rider / Legal Guardian: _____ Date: _____

Printed Name: _____

For Internal KAT Use Only**REOCCURRING SCHEDULE**

Pickup

Time

Start Date

Destination

Time

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday☐ Weekly ☐ In Service Area ☐ In County☐ Bi-Weekly ☐ Out of Service Area ☐ Rural ☐ Out of County

Rider Master Entry

Subscription Entered

Scanned

Filed