WONDERFOLD® WAGON

WonderFold Wagon Special Needs Discount Application Form

Parent/Legal Guardian Name _____

Parent/Legal Guardian Email _____

Patient Name _____

Date of Birth _____ - _____ - _____

Address _____

Section below must be completed by the patient's medical care provider (Physician, Physical Therapist, Medical Social Worker, or Child Life Specialist).

Name _____ Title _____

License Number _____

Hospital or Medical Institution Name _____

Patient's Medical Diagnosis _____

Please describe how our stroller wagons will benefit the patient emotionally, physically, psychologically, and/or socially _____

_____

_____

_____

Will our stroller wagon products be a part of the patient's medical treatment plan? Yes / No

_____ _____ _____

Legal Guardian's Signature Medical Care Provider Signature Date