



WonderFold Wagon Special Needs Discount Application Form

This form MUST be completed by the patient's medical care provider.

(Physician, Physical Therapist, Medical Social Worker or Child Life Specialist)

Name _____ Title _____

License Number _____ State Provider is Licsened in _____

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